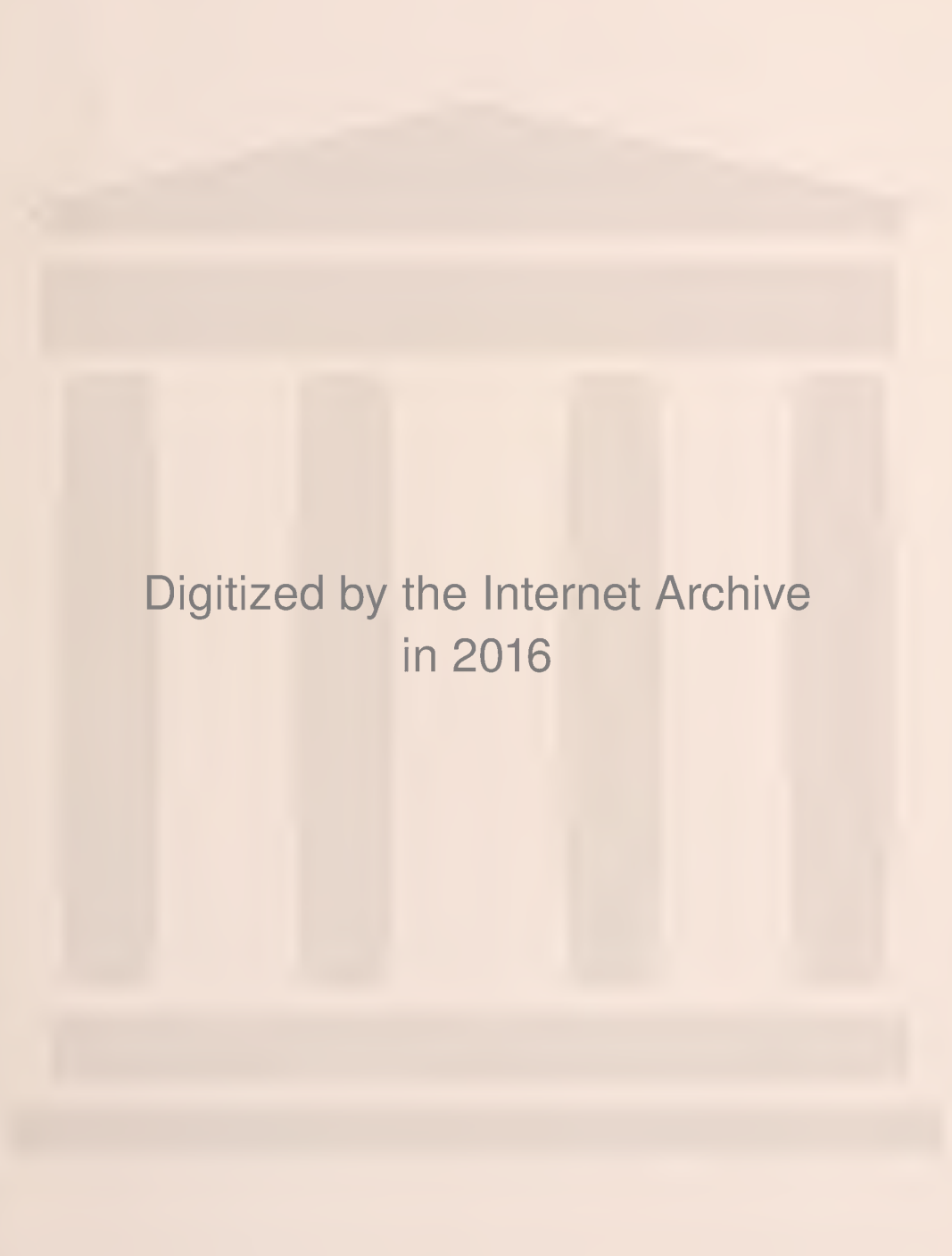


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January 1983

JOURNAL **of the MISSISSIPPI** **State Medical Association**

Incarcerated Obturator Hernia

Blunt Thoracic Aortic Injuries

**Management of Vaginal Agensis:
Report of a Case**

**A Look at the Peer Review
Improvement Act of 1982**

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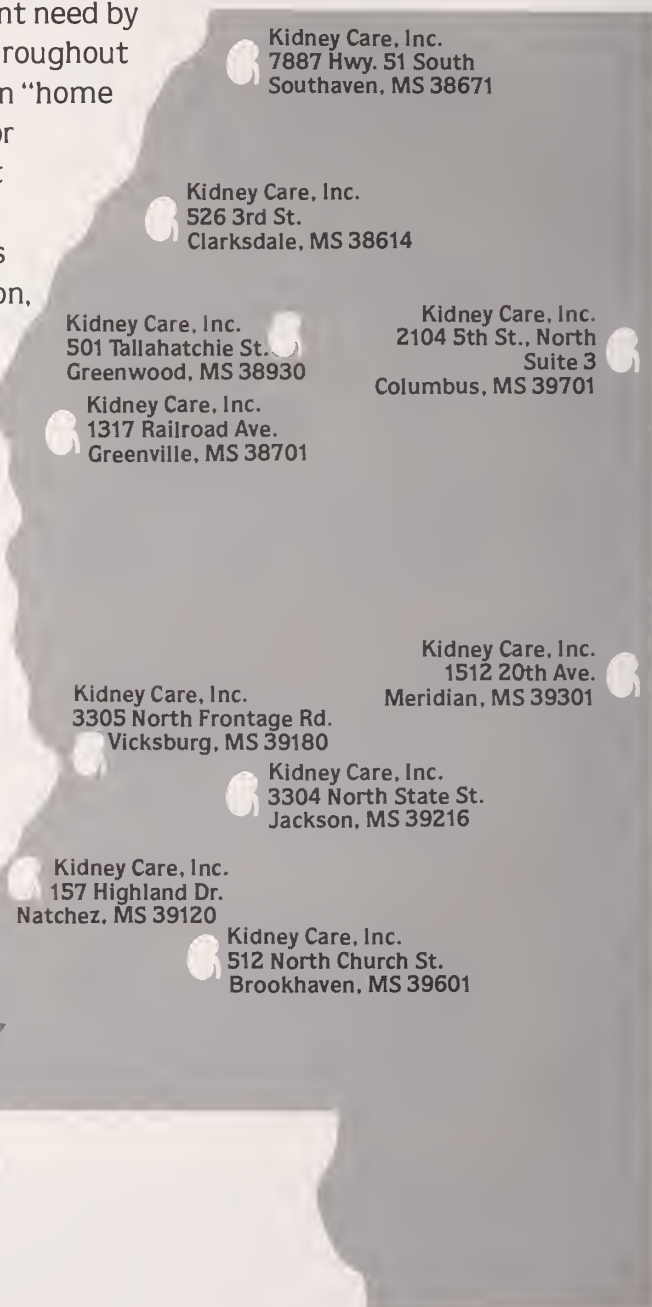
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January 1983, Volume XXIV, Number 1

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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 19-23, 1983, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

Mississippi State Medical Association, 115th Annual Session, May 11-15, 1983, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, July 6-9, 1983, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39221.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 3rd Wednesday, January, May, and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Pres. and Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, State, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March,

June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Albert H. Laws, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Douglas F. Thomas, Secy., 415 South 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

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Mississippi State Medical Association
735 Riverside Drive
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830 Gloster Avenue
Tupelo, MS 38801

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1225 N. State Street
Jackson, MS 39201

Gulf Coast Community/Gulfpport
Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

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Sardis, MS 38666

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2809 Denny Avenue
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POSTGRADUATE CALENDAR

February 3-4, 1983

RENAL UPDATE 1983: REHABILITATION IN
CHRONIC ILLNESS

Sheraton Regency, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Medicine, the School of Nursing and the UMC Division of Continuing Health Professional Education. Co-sponsors are Kidney Care, Inc.; the Kidney Foundation of Mississippi; the Mississippi Nephrologic Society and the Mississippi Urologic Society.

This year's symposium will focus on returning a patient with chronic illness to a productive life using kidney disease as a prototype. The seminar will also cover pulmonary, cardiac and gastrointestinal disorders. Fee: \$70. Credit: 9.1 contact hours AMA Category 1, 9.1 contact hours AAFP.

March 10-12, 1983

POST GRADUATE SURGICAL FORUM X
Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery and

the Medical Center Division of Continuing Health Professional Education.

Coordinator: J. Harold Conn, M.D., professor of surgery and Chief, Division of Surgery, Veterans Administration Medical Center.

Sessions will include controversial problems in surgery, endocrine surgery, vascular surgery, surgical oncology and biliary-pancreatic surgery. Registrants are invited to bring problem cases, along with x-rays, to present for discussion during conferences. An outstanding guest faculty will join Mississippi Medical Center faculty members in presenting the sessions. Fee: \$275. Credit: 22 hours in Category 1 of the AMA Physician's Recognition Award.

FUTURE CALENDAR

March 17-18, 1983

MEDICINE IN THE OLD SOUTH

University Medical Center, Jackson

March 26, 1983

PHOTOGRAPHY UPDATE FOR EDUCATION AND
SLIDE PROGRAMS

Kessler Air Force Base, Biloxi

For more information contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: (601) 987-4914.

Surgical Forum Set; Faculty Announced

The University of Mississippi Medical Center will host its 10th annual Surgical Forum March 10-12, 1983, at the Holiday Inn Downtown in Jackson.

Sponsors are the University of Mississippi School of Medicine Department of Surgery and the Medical Center Division of Continuing Health Professional Education. Dr. James D. Hardy is professor and chairman of the Department of Surgery at the Mississippi Medical Center. Dr. J. Harold Conn, Mississippi professor of surgery and chief of surgery at the Veterans Administration Medical Center. Dr. J. Harold Conn, Mississippi professor of surgery and chief of surgery at the Veterans Administration Medical Center in Jackson is course coordinator.

Sessions will focus on controversial surgical problems and surgical challenges.

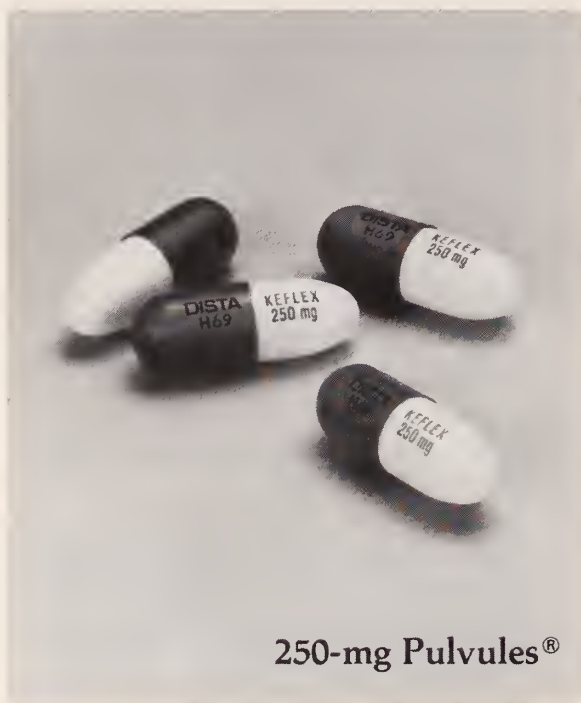
Joining the Mississippi faculty in presenting the program will be guests Dr. William Laurence Done-

gan, Medical College of Wisconsin; Dr. Frederic E. Eckhauser, University of Michigan; Heber A. Ladner, Jr., partner in the law firm of Upshaw and Ladner of Jackson, specializing in the defense of professional liability claims against physicians; Dr. John E. Ray, Tulane University; Dr. Norman M. Rich, Uniformed Services University of the Health Sciences, Bethesda, Md.; Dr. David Bernt Skinner, University of Chicago; Dr. Paul H. Sugarbaker, Uniformed Services University of the Health Sciences; Dr. Colin G. Thomas, Jr., University of North Carolina; and Dr. E. R. Woodward, University of Florida.

Enrollment is limited. Registration fee is \$275; credit of 22 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association will be given for full attendance.

For information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

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NEWSLETTER

January 1983

Dear Doctor:

The 1983 Regular Session of the Mississippi Legislature convened on January 4 in the newly renovated Capitol building. Watch for information about MSMA's legislative proposals, which will be described in upcoming issues of the MSMA "Blue Sheet." Included in the association's legislative goals are six bills designed to slow the rise in professional liability insurance rates.

For the 18th consecutive year the association will provide an Emergency Medical Care Unit for legislators, staff and visitors to the Capitol. Mavis Barlow, R.N., and volunteer Doctors of the Day will again staff the EMCU. For information on available dates, please call the MSMA office.

Last month the association began a statewide information campaign concerning the malpractice crisis in Mississippi. The campaign includes a series of television announcements and an informational brochure which cites the profession's concern for the situation, describes the resulting cost to the public, and outlines the development of the crisis and possible solutions.

The public has strong pro-physician attitudes on professional liability issues, according to a survey conducted by the AMA. Most people do not think that malpractice suits are usually justified, although a considerable number (47%) hold the opposite view. A majority (61%) of the public respondents favored limits on awards, and 47% think current awards are too high.

Better physician-patient rapport was cited by 92% of physicians as a very effective method of reducing professional liability risk, the same survey found. MSMA's new patient inquiry program, CommuniCare, is designed to help improve physician-patient rapport by improving communications. The program's first stage got underway last month in the Vicksburg area.

Two important events are on the MSMA calendar for early 1983. One is March 5-6, when there will be a seminar in Jackson for MSMA and Auxiliary members. The program includes a session on "Critical Issues in Health Care" and a political action workshop. Another important date is May 11-15, when the MSMA's 115th Annual Session will take place in Biloxi. See you there!

Sincerely,



Patsy Silver
Managing Editor

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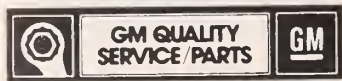
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Review A Book

The following books have been received. Members of MSMA interested in reviewing any of these volumes should address their requests to Editor, JOURNAL MSMA, P.O. Box 5229, Jackson, MS 39216. After submitting to the JOURNAL a review for publication, you may keep the books for your personal libraries.

Physician's Handbook: Twentieth Edition. Los Altos: Lange Medical Publications, 1982. \$12.00.

Current Medical Diagnosis & Treatment. Edited by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. Los Altos: Lange Medical Publications, 1982. \$26.00.

Current Pediatric Diagnosis & Treatment: Seventh Edition. Los Altos: Lange Medical Publication, 1982. \$26.00.

Basic & Clinical Immunology: Fourth Edition. Los Altos: Lange Medical Publications, 1982. \$22.00.

Current Obstetric & Gynecologic Diagnosis & Treatment: Fourth Edition. Edited by Ralph C. Benson, M.D. Los Altos: Lange Medical Publications, 1982. \$25.00.

Principles of Clinical Electrocardiography: Eleventh Edition. Edited by M. J. Goldman, M.D. Los Altos: Lange Medical Publications, 1982. \$15.00.

Basic and Clinical Pharmacology. Edited by Bertram G. Katzung, M.D., Ph.D., Los Altos: Lange Medical Publications, 1982. \$23.50.

Handbook of Poisoning: Eleventh Edition. Robert H. Dreisbach, M.D., Ph.D. Los Altos: Lange Medical Publications, 1983. \$11.00.

Clinical Cardiology: Second Edition. Edited by Maurice Sokolow, M.D. and Malcolm B. McIlroy, M.D. Los Altos: Lange Medical Publications, 1982. \$17.50.

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DATELINE

Dedication Set For Acute Services Wing Jackson, MS - State physicians are invited to attend the dedication of the new University Hospital acute services wing, set for February 17 at the University Medical Center. There will be a brief formal ceremony at 1:00 p.m., after which tours and a reception will take place. The wing will provide a new operating suite, emergency room and recovery and intensive care units. The new emergency room is said to be one of the nation's largest.

Medicaid Outlays Slow Dramatically Washington, DC - The growth of Medicaid outlays slowed dramatically to 9.8% in fiscal 1982, the first time it ever has dropped below double digits, government figures show. The Department of HHS is proposing a \$5 billion cut in both Medicaid and Medicare in fiscal 1984. Proposed savings are expected to come from changes in reimbursement policies to hospitals and physicians, including the possibility of statewide negotiated fee schedules for physicians.

Imported Measles Still A Problem Chicago, IL - Despite an apparently successful national effort to eliminate indigenous measles in the U.S. by the end of 1982, measles cases continued to be imported by travelers, according to a report from the CDC in a recent issue of JAMA. Data for 1980 and 1981 showed an increase in the number of cases. Additional victims were infected through association with imported cases. The total of reported cases for the two years was 16,630.

Immunization Warning Issued Chicago, IL - A significant proportion of adult men and women in the U.S. may never have been adequately immunized against tetanus and diphtheria or their immunity may have waned, states a report in a recent issue of JAMA. More than half of those at greatest risk of exposure to diphtheria, such as hospital employees, may not be properly immunized, says the article, which also cautions that women during their reproductive years and adults over 50 may not be protected against tetanus.

Tax on Health Insurance Benefits Washington, DC - A tax on part of the health insurance benefits that employees receive from employers has been proposed by Administration officials. Supporters say the tax not only would generate several billions in revenue, but also would help control medical costs, which have been rising twice as fast as the consumer price index. The proposal is likely to be included in the budget that President Reagan will send to Congress in mid-January.

RECOLLECTIONS

Scientific topics presented at the AMA's 16th Clinical Session, according to a report in the January 1963 issue of JOURNAL MSMA, included air pollution, cancer, muscular dystrophy, aerospace medicine, hepatitis, viruses, problems of the aged, and suicide prevention. According to the Journal's three-page summary article, the suicide prevention symposium was the most talked-about presentation. It featured six essayists, including the Los Angeles psychiatrist who was called to investigate the death of actress Marilyn Monroe, and attracted a standing-room-only audience. One of the speakers, a Florida biostatistician, reported that 30 years earlier suicide was more prevalent in low income groups, but in 1963 it had become more prevalent among top income earners.

The Journal's report of the AMA meeting in Los Angeles also included summary of House of Delegates actions, which included a call for revision by Congress of the Kerr-Mills law and the adoption of four proposed amendments to the Internal Revenue Code of 1954. Delegates warned that immunization against smallpox was at a dangerously low level in the United States, and in another action, urged closer liaison between medical societies and public health departments, stressing the need for a proper balance between public health programs and the private practice of medicine.

MSMA members were prominent in state and regional medical news, according to reports in that same issue of the Journal twenty years ago. Dr. Stanley A. Hill of Corinth was to be inaugurated president of the Mid-South Postgraduate Medical Assembly during its upcoming meeting; Dr. Guy T. Vise of Meridian had been named chairman of the 17-member governing Council of the Southern Medical Association; and Dr. H. C. Ricks had been honored in a ceremony upon his retirement from the State Board of Health.

January 1963 was a time for reflecting upon medical advances during 1962, and the Journal included a report which identified some major developments. One of the most notable was in the field of genetics, where three Nobel Prize winners had made breakthroughs in deciphering DNA's code.

Another major development which offered the possibility of a major advance was the report that application of the drug 5-iododeoxyuridine could kill herpes simplex virus.

A Brief Summary

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CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program.

Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.

Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.

Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.

Allergic: Urticaria.

Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.

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The University of Mississippi Medical Center will present its annual renal disease seminar February 3-4, at the Sheraton Regency in Jackson.

The course is designed for physicians, nurses, dietitians and social workers. This year's symposium will focus on rehabilitating the chronically ill, using kidney disease as a prototype. Pulmonary, cardiac, and gastrointestinal disorders will also be included.

Course coordinator is Dr. John Bower, professor of medicine and director of the UMC artificial kidney unit. Guest faculty are Peggy Burns, R.N., B.S.N., Jerry Fuller, M.S.W., Lynn M. Haynes, R.N., B.S.N., Nancy H. Teal, R.D., and Harriet Williamson, R.N., all from Kidney Care, Inc., of Jackson; Steve Gullette, R.N., of Kidney Care, Inc., Vicksburg; Camille Wade Maurice, A.C.S.W., Mental Health Consultant, Neenah, Wisconsin; George Shreiner, M.D., Georgetown University, Washington, D. C.; and Robert W. Tabscott, Th.M., St. Louis University Medical School, Minister Des Peres Presbyterian Church, St. Louis, Mo.

The program is sponsored by the UMC School of Medicine Department of Medicine, the School of Nursing and the UMC Division of Continuing Health Professional Education. Co-sponsors are Kidney Care, Inc.; the Kidney Foundation of Mississippi; the Mississippi Nephrologic Society and the Mississippi Urologic Society.

Course fees are \$70 for physicians, \$40 for nurses, dietitians and social workers, and \$25 for students. Credit for the workshop is 11.3 contact hours from the Mississippi Nurses' Association, 9.1 contact hours of the American Medical Association Category I, and 9.1 hours of the American Association of Family Practitioners.

For further information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601) 987-4914.

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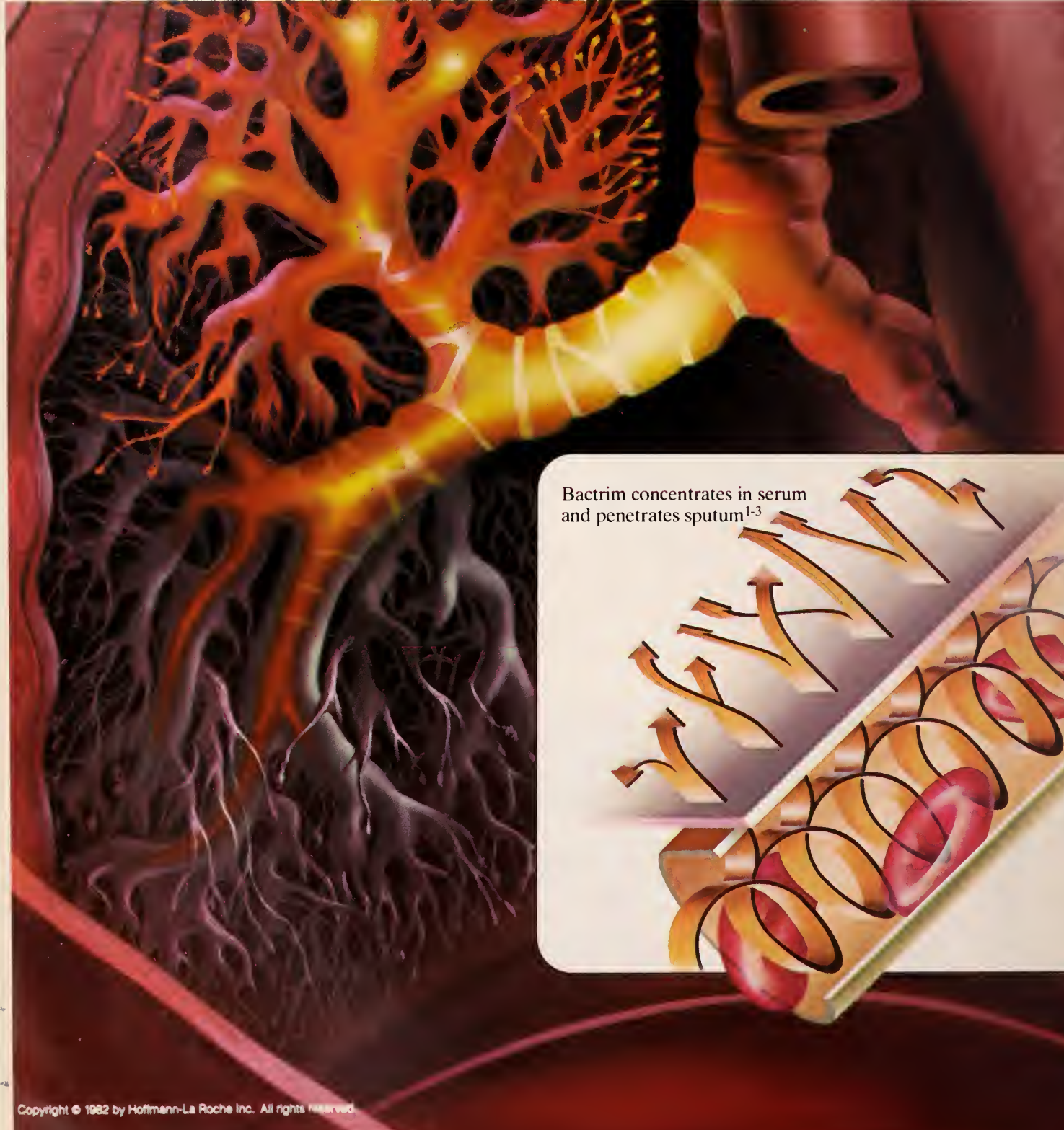
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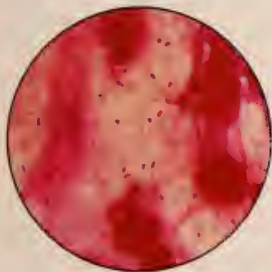
involving nearly 700 patients.¹⁰ Overall clinical condition of the patients, changes in sputum purulence, reduction in sputum volume and microbiological clearance of pathogens—all improved more with Bactrim therapy than with tetracyclines. G.I. side effects occurred in only 7% of patients treated with Bactrim compared with 12% of tetracycline-treated patients. (See Adverse Reactions in summary of product information on next page.)

Bactrim is contraindicated in pregnancy at term and nursing mothers, infants under two months of age, documented megaloblastic anemia due to folate deficiency and hypersensitivity.

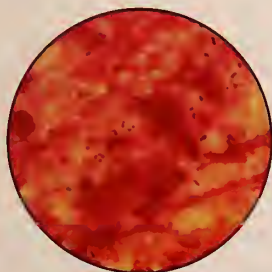
Bactrim DS. For acute exacerbations of chronic bronchitis in adults* when it offers an advantage over single-agent antibacterials.

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For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hemopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp (20 ml) b.i.d. for 14 days.

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Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

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ORIGINAL PAPERS

Incarcerated Obturator Hernia

W. WILSON DEFORE, JR., M.D. and RAYMOND S. MARTIN, JR., M.D.

Jackson, Mississippi

THE PELVIC WALL region is one of many potential sites of herniation within the abdominal cavity; however, herniae presenting through the foramen and the musculoskeletal floor of the pelvis are relatively rare. An infrequently encountered hernia of this type is the obturator hernia which is rarely palpable or visible, therefore rarely diagnosed before surgical intervention. The obturator hernia usually presents with intestinal obstruction secondary to incarceration of the bowel contents within the rigid walls of the obturator foramen. Presented with this paper is a case report and a review of the clinical spectrum of obturator hernias.

Case Report

A 95-year-old white female, B.M., was admitted to the hospital on 11-21-81 in a severely emaciated and cachectic state with complaints of lower abdominal pain. The patient gave a history of nausea and vomiting, cramping abdominal pain, recent weight loss and anorexia. Approximately one week prior to admission she had experienced a similar episode of cramping abdominal pain which had spontaneously abated. Past medical history revealed that she had been treated for atherosclerotic cardiovascular disease as well as chronic obstructive pulmonary disease.

On physical examination she presented as a chronically ill-appearing female in a lethargic state. The skin was noted to be dry as well as the mucous membranes, reflecting a moderate degree of dehydration. Examination of the abdomen revealed a

Obturator herniae characteristically affect females in the seventh and eighth decades of life, and are more frequently noted on the right side than the left. The majority of these herniae will be found to contain small bowel, and producing a picture of small bowel obstruction. The authors report that the diagnosis is suggested by a clinical picture of intestinal obstruction, together with a positive Howship-Romberg sign, and the presence of a palpable mass. Often a history of previous episodes of intermittent intestinal obstruction followed by spontaneous remission is noted in these patients. An abdominal approach through a lower midline incision is the treatment of choice, and the site of the hernia opening can be closed by a variety of techniques. The preoperative diagnostic accuracy rate still remains in the range of 30%, and the mortality is high in this group of patients due to their advanced age and associated disease processes.

thin abdominal wall, and lower abdominal distention with hypoactive bowel sounds and discomfort to deep palpation. Admission laboratory data showed a white blood cell count of 15,000 with a shift to the left, and the abdominal x-ray was suggestive of small bowel obstruction.

The patient was prepared for surgery with nasogastric suction, intravenous fluid replacement and

The authors are engaged in the private practice of surgery in Jackson, Mississippi.

antibiotic therapy. At the time of laparotomy a segment of ileum was found incarcerated within the obturator foramen. This presented as a Richter's-type herniation, involving only a partial circumference of the bowel and was manually reduced with the bowel still in a viable state. Postoperatively the patient required hyperalimentation for nutritional support, mechanical ventilatory assistance, and Swan-Ganz monitoring to aid in fluid balance and cardiorespiratory dynamics. Despite aggressive therapy, the patient experienced progressive deterioration with respiratory failure and expired 18 days postoperatively.

Discussion

The obturator hernia is an infrequently encountered hernia of the pelvic floor region. They are classified by Nyhus with the anterior group of pelvic herniae which also included inguinal and femoral herniae.⁴

The obturator hernia was originally described by Roland Ronsil in 1724 in a report before the Royal Academy of Surgeons in Paris. The first attempt at a surgical repair was reported by Hilton in 1848, and the first successful operation on record was by Henry Obre in 1851, when he repaired an obturator hernia by an extraperitoneal approach. John Howship and Moritz Romberg first described the characteristic pain radiating down the medial aspect of the thigh which is produced by pressure on the obturator nerve, and thought to be pathogomonic of an obturator hernia.⁴

The obturator region is located in the medial portion of the upper third of the thigh between the extensor and flexor muscle groups. The obturator foramen is the largest foramen in the body and is formed by the rami of the ischium and the pubis. It lies on the anterior rim of the pelvic wall inferior to the acetabulum. Essentially all the area of the foramen is closed by the obturator membrane, the fibers of which are continuous with the periosteum of the surrounding bone and the tendinous attachments of internal and external obturator muscles. The obturator canal is a tunnel two to three centimeters long which begins at the pelvis at the defect in the obturator membrane, and passes obliquely downward to end outside the pelvis in the obturator region of the thigh. It is bordered superiorly and laterally by the wall of the obturator groove of the pubic bone and interiorly by the free edge of the obturator membrane, along with internal and external obturator muscles. Enclosed within this canal are the obturator nerve, artery and vein² (see Figure 1).

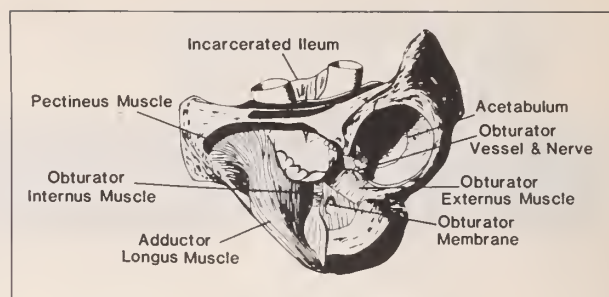


Figure 1. Obturator hernia.

The formation of an obturator hernia is characteristically described in three stages.³ The initial stage or "pre-hernia stage" starts with the entrance of pre-peritoneal connective tissue and fat into the pelvic orifice of the obturator canal. In fact, many cases arrest at this stage with "pilot tags" and no subsequent internal dimpling of the peritoneum is noted. The second stage begins with the appearance of a dimple in the peritoneum over the internal opening of the obturator canal and progresses with invagination of the peritoneal sac. The third or final stage begins with the onset of symptoms which are produced by the entrance of an organ, usually the ileum, into the hernia sac. If only a portion of the bowel circumference is incarcerated, a Richter's hernia results; however, if an entire loop enters the sac, the obstruction will be complete and may progress to strangulation.

Characteristically, obturator herniae are seen more frequently by a six to one ratio in females since the obturator foramen is smaller and of a more triangular shape. Most commonly the hernia is seen in females in the seventh and eighth decade, and they often appear chronically ill. The most common content of the hernia sac has been reported to be the ileum which is frequently incarcerated, and presents with intestinal obstruction.⁴

The diagnosis of an obturator hernia is suggested by the clinical picture of intestinal obstruction, a positive Howship-Romberg sign, and a history of previous attacks. The symptoms of an obturator hernia are usually acute in onset and become progressively more severe with signs and symptoms of intestinal obstruction. Approximately 50% present with a Howship-Romberg sign with pain extending down the inner surface of the thigh to the knee area, produced by pressure along the obturator nerve and the geniculate branch to the knee. Flexion of the thigh usually relieves this pain while extension,

adduction, or medial rotation exacerbates the pain. Rarely is the hernia visible since the hernia is covered by the pectineus muscle. It seldom causes a swelling in Scarpa's triangle unless the limb on the ipsilateral side is flexed, abducted or rotated outward. Rectal and vaginal palpation may help in locating the hernia sac which can be felt as a tender swelling in the area of the obturator foramen. Approximately 30-40% of the patients have a history of previous attacks or acute intestinal obstruction with subsequent remission.

A variety of surgical techniques for the repair of obturator herniae have been suggested. The preferred approach is abdominal through a lower mid-line incision with the patient in the Trendelenberg position. At the time of surgery the pelvis can be inspected and the herniated contents reduced. If incarceration is present, the lower portion of the obturator membrane should be incised, since the vessels and nerves lie lateral to the sac in 50-60% of the cases. It is felt that the abdominal approach is superior since it permits the advantages of establishing the diagnosis while allowing the best exposure of the obturator ring and the least danger to the obturator vessels. In addition, the abdominal approach allows resection if the small bowel blood supply has been compromised. Other described approaches include

the retropubic approach which may have advantages in the patient in which the correct diagnosis has been made prior to surgery. Also, the obturator approach may be applicable if there is a palpable mass in the obturator area. Should a mass be present, the thigh should be flexed and adducted, and a generous incision made just above the mass. The repair of the defect can be carried out after reduction of the contents, and the hernia sac should be inverted and ligated with the redundant portion excised. Effective closure may be obtained by the use of periosteal flaps, autogenous fascia, or prosthetic materials as necessary.^{1, 4} The mortality rate still remains in the range of 10-15%, primarily due to the advanced age of these patients and their associated disease processes.

★★★

514-A E. Woodrow Wilson (39216)

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Blunt Thoracic Aortic Injuries

G. DENNIS VAUGHAN, III, M.D.* and FRED A. CRAWFORD, JR., M.D.*

Charleston, South Carolina

BOBBY J. HEATH, M.D.†

Jackson, Mississippi

ALTHOUGH RECENT HIGHWAY speed limit reductions have slightly decreased mortality from motor vehicle accidents, blunt thoracic aortic injury remains one of the primary causes of death in these victims. It is estimated that 10-20% of fatal accident victims sustain aortic rupture. Instant death occurs in approximately 80% of the victims while 10% die within the first 24 hours, and 10% go on to develop a chronic aneurysm if it is not detected initially.^{1, 2}

For many years the standard surgical approach to this injury involved the use of cardiopulmonary bypass. Because of complications with this method — primarily excessive bleeding secondary to obligatory heparinization — other techniques have been used more recently. In the early 1970's a heparin bonded shunt was developed and has been utilized to bypass the involved area while repair is made.³ More recently simple cross-clamping of the thoracic aorta without bypass has been advocated.⁴ Obviously neither of these techniques requires systemic heparinization but more important from a practical standpoint, either of the latter two methods may be used in hospitals where cardiopulmonary bypass is not available.

Most patients with traumatic aortic injuries either die instantly or remain stable enough to allow transportation to a large referral center for repair. Occasionally, however, such an injury demands surgery before transportation can be arranged. The purpose

Blunt thoracic aortic injury is one of the primary causes of death in motor vehicle accident victims. The authors maintain that with early detection and excellent surgical treatment, many patients with this type of injury can be successfully treated. They describe experience at two medical centers in treating six patients with this type of injury and demonstrate different approaches to treatment.

of this article is to increase awareness of this injury in accident victims and to demonstrate different techniques of repair which are available. Recent experience at two large university medical centers will demonstrate approaches in handling these patients.

Clinical Material

Since 1978, numerous patients have been seen at the University of Mississippi Medical Center and the Medical University of South Carolina with acute traumatic injury to the thoracic aorta sustained in motor vehicle accidents. Six have been selected to demonstrate different techniques of repair. Three patients were referred to the University of Mississippi Medical Center in Jackson within hours of injury for evaluation of multiple trauma and possible aortic injury. Age ranged from 18 to 78 and all presented with hypotension, various extremity and pelvic fractures, and chest x-rays revealing a widened mediastinum and partial left chest opacification (see Figure 1). Following stabilization, each underwent aortography which revealed an aortic injury just distal to the left subclavian artery (see Figure 2). The patients were taken immediately to the operating

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room and all injuries were approached through a left thoracotomy. A heparin bonded shunt was utilized in each patient to bypass the injury. The proximal insertion point was the ascending aorta in one, the left ventricular apex in one, and the left subclavian artery in one. Distally the shunts were placed in the left common femoral artery (see Figure 3). The aortic injuries were repaired with dacron grafts and aortic cross-clamp time ranged from 23 to 36 minutes. All patients survived, and there were no complications associated with the aortic injury or its method of repair.

Three patients, all in their early thirties, were referred to the Medical University of South Carolina Hospital following motor vehicle accidents. Similar associated injuries were present as was the radiologic evidence for injury to the thoracic aorta. One patient presented with a mild left hemiparesis. Aortography confirmed injury to the descending thoracic aorta just distal to the left subclavian artery. In two patients, the injuries were approached through a left thoracotomy and the aorta was cross-clamped without the use of a shunt and the injury repaired

with a dacron graft. Aortic clamp time was 34 and 37 minutes in these patients. Both patients survived, and one patient had no complications associated with the injury, while the patient who presented with the hemiparesis remains hemiparetic. In the final patient, similar repair was planned but at surgery, a large hemothorax was discovered due to bleeding from the injury. The extent of the injury was so extensive that a prolonged clamp time was predicted. For this reason and because of excessive bleeding, it was elected to use partial cardiopulmonary bypass (femoral artery to femoral vein). The repair was carried out without difficulty, and the patient recovered without incident.

Discussion

Aortic rupture occurs as a result of stresses caused by unequal rates of horizontal deceleration of different portions of the aorta, especially at points of fixation. The fixation point at the aortic isthmus is the area least resistant to stress and is the most common site (80-90%) of transverse tears which result in partial or full thickness transections. The partial tears are the ones that go onto false aneurysm formation, and of these patients left untreated, 80-90% will die from rupture if left unattended for greater than three weeks. For these reasons, it is



Figure 1. Initial emergency room x-ray showing a widened mediastinum and left hemothorax.



Figure 2. Aortogram showing peri-aortic hematoma and intimal disruption.

AORTIC INJURIES / Vaughan et al

imperative that the diagnosis be established promptly and surgical repair begun as soon as possible. In victims of high speed deceleration accidents, the index of suspicion of this injury must be high since in some reported series, 33-50% of patients had no external evidence of chest injury. Kirsh from the University of Michigan cited their 10 year experience with 43 patients. The most common clinical

findings were upper extremity hypertension, intra-scapular systolic murmur, and evidence of external chest wall injury.²

Routine chest roentgenography is invaluable in increasing the index of suspicion. Radiologic clues are not necessarily specific, but when present, should be highly suggestive for confirmation by aortography. Marsh and Sturm proposed 6 radiologic indications for thoracic aortography following blunt chest trauma:⁵ (1) superior mediastinum greater than 8cm on 100cm AP supine chest film; (2) tracheal shift to the right, (3) blurring of the aortic outline; (4) obliteration of the medial aspect of the left upper lobe apex; (5) opacification of the clear space between the aorta and the left pulmonary artery; and (6) depression of the left main bronchus below 40°.

Another indication for aortography as evidenced by our patients is massive left hemothorax. Aortography is not only important for establishing a definitive diagnosis, but it can also provide knowledge as to site or sites of rupture, estimation as to the size of the false aneurysm, and it can also prevent unnecessary thoracotomy in an otherwise critically ill patient. Once aortography has confirmed the diagnosis, operative repair is mandatory as soon as possible. Only severe neurological injury requiring immediate intervention or exsanguinating bleeding as from ruptured spleen takes precedent over repair of the aortic injury.

Cardiopulmonary bypass has been long used for repair of traumatic thoracic aortic injuries. Advantages include salvage of blood if the patient is actively bleeding and some degree of spinal cord and renal protection, especially with long clamp times. The necessity for systemic heparinization can in itself cause excessive bleeding from the graft and repair as well as from other sites of injury (CNS, fractures, etc.). The technique is usually available only in large referral centers with open heart surgery programs.

The heparin bonded shunt permits bypass around the injury, thus providing some protection to the kidney and spinal cord, but does not require systemic heparinization. As mentioned, the latter may be a real disadvantage in the patient with multiple trauma. The shunt may be inserted proximally into the subclavian artery (as originally designed) or equally well into the ascending aorta or left ventricular apex and distally it is usually inserted into the common femoral or external iliac artery. Meticulous technique is necessary to avoid arrhythmias and bleeding from cannulation sites. This method can be employed by a well trained vascular/thoracic surgeon in a community hospital.

The most simple method of repair involves cross-

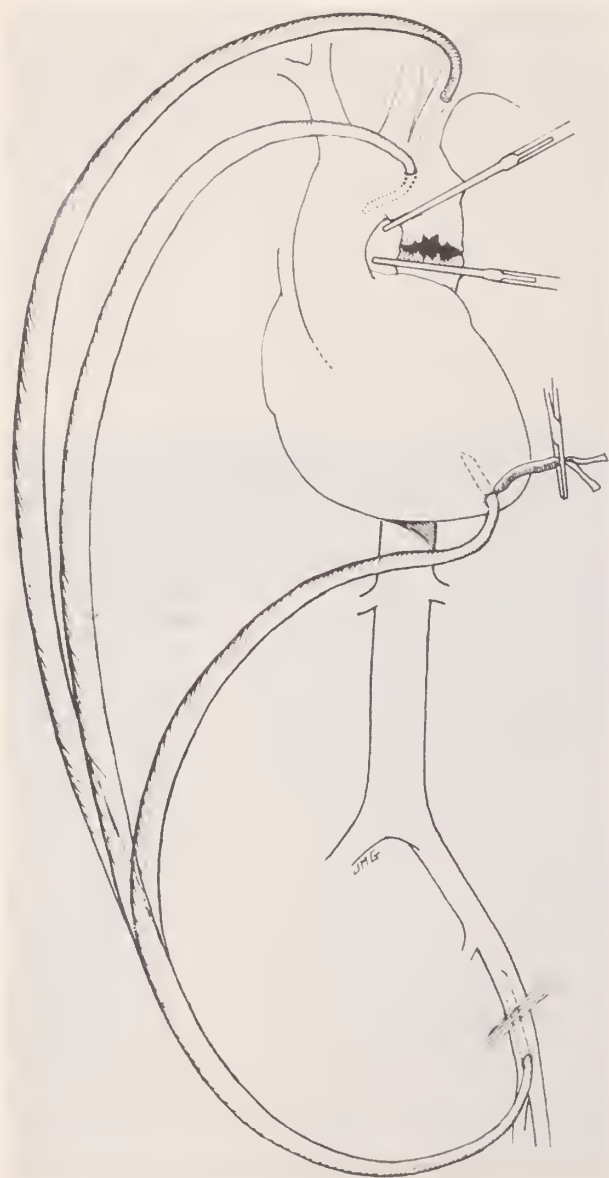


Figure 3. Illustration depicting proximal and distal insertion sites of heparin bonded shunt.

clamping of the aorta above and below the site of injury and repair of the injury.⁴ Again, systemic heparinization is not necessary. However, aortic cross-clamping at this level significantly increases left ventricular afterload, and may cause arrhythmias and heart failure, particularly in older patients with underlying cardiac disease. Close cooperation between the surgeon and anesthesiologist, along with the use of afterload reducing agents such as nitroprusside may prevent these problems. Time is important if this method is to be used and cross-clamp time should not exceed 30 minutes in order to prevent injury to the kidneys or spinal cord.

Thoracic aortic injuries should be suspected in any patient with severe trauma. Diagnosis is made by aortography. If at all possible, these patients should be transported immediately to a center with both facilities for cardiopulmonary bypass and surgeons experienced in this injury. If this is impossible, techniques are available which enable experienced surgeons to repair *most* of these injuries without cardiopulmonary bypass. With early detec-

tion and excellent surgical treatment, most patients with this type of injury can be successfully treated.

★★★

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Management of Vaginal Agenesis: Report of a Case

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Jackson, Mississippi

CONGENITAL ABSENCE of the vagina occurs in approximately 1 in 5000 female births,¹ but if considered from the standpoint only of women presenting with primary amenorrhea, the disorder is fairly common. Indeed, in 538 patients from nine case-series summarized by Ross and Vande Wiele,² congenital absence of the vagina ranked second only to gonadal dysgenesis as a cause of primary amenorrhea. Rein-dollar et al,³ in a single series of 252 patients with abnormal pubertal development, found vaginal agenesis to be the second-most common cause of primary amenorrhea.

Vaginal agenesis is unlike other disorders of puberty in the female where sexual maturation either fails to occur or is truncated. In congenital absence of the vagina, secondary sexual development (ie, breast development and sexual hair growth) is normal. The presenting complaint of afflicted women is failure to menstruate or failure to successfully achieve coitus.

In this report we present a case of congenital absence of the vagina associated with renal and skeletal abnormalities. We specifically emphasize the surgical management and appropriate timing of surgery in this unusual condition.

Case Report

K. W., a 17-year-old black female, was referred to the Reproductive Endocrinology Clinic at the University of Mississippi Medical Center for evaluation of primary amenorrhea. As a child she suffered severe burns to the back and lower extremities that

Vaginal agenesis is a rare disorder, but when considered in young women presenting with primary amenorrhea it is fairly common. The authors present a case history of a young woman with vaginal agenesis and describe the surgical management of her condition. They stress the need for early surgical correction of vaginal agenesis to help these young women avoid psychologic complications and to establish healthy heterosexual relationships.

required extensive skin grafting. At age 6 she was noted to have severe scoliosis, but no ongoing treatment had been rendered for this condition. At age 11 years breast development began and was followed by pubic and axillary hair growth. At age 14 years she noted cyclic abdominal bloating and breast fullness. Yet she never menstruated. She was referred at age 17 years for further evaluation.

Physical examination revealed a well-developed black woman who was 63 inches tall and weighed 121 pounds. She had severe scarring of the back with keloid formation from her childhood thermal injury and marked scoliosis of the thoracolumbar spine. Examination of the HEENT, neck, chest, heart, and abdomen was normal. The breasts were fully developed. Examination of the external genitalia revealed normal labia majora and labia minora. The urethra was normal. The vaginal introitus was covered by a thick, pink membrane that had no opening (see Figure 1). On rectal examination the uterus could not be palpated.

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Figure 1. Examination of the perineum and introitus prior to surgery revealed absence of the vaginal opening.

An intravenous pyelogram revealed a solitary right pelvic kidney. The left kidney was congenitally absent.

The patient was taken to the operating room, and a modified McIndoe vaginoplasty was performed. A 4 x 8 inch split-thickness skin graft was taken from the right buttock. The potential vaginal space between the urethra and rectum was opened by blunt and sharp dissection; the dissection carried to the peritoneal reflection. A stint was carved in the operating room from a block of styrofoam to conform to the vaginal space. The stint was covered with a condom; the skin graft was sutured across the stint with the raw surface exposed (see Figure 2). The stint covered by the skin graft was placed into the created vaginal space, and the labia were closed over the stint with silk retention sutures. A Foley catheter was placed in the bladder.

This apparatus was left in place for seven days; the patient was maintained at strict bed rest. On the eighth day the styrofoam mold was removed and the



Figure 2. This illustrates the skin graft and the mold (covered by a condom) to be transplanted into the vaginal space. The skin graft was subsequently sutured across the mold.

vagina irrigated with saline and hydrogen peroxide. A permanent mold, carved from balsa wood and covered by a condom, was placed in the vagina. The patient was instructed in cleansing the vagina, removing the mold, and replacing the mold. She was instructed to wear the mold continuously (except for cleansing and douching) for six months.

Six months after surgery the vagina was covered by a moist, pigmented epithelium (see Figure 3). The vaginal depth was 10 centimeters; the perivaginal tissue including the introitus was pliable and distensible.

One year after surgery she became sexually active and was able to achieve sexual intercourse. Upon questioning, she reported that her vagina became lubricated with sexual stimulation; she was orgasmic.

Discussion

Vaginal agenesis has been known since antiquity.⁴ In his book, *On the Nature of Woman*, Hippocrates gives a description of obstruction of the vaginal canal. Celsus, a first century Roman medical writer and historian, gives a full description of imperforate hymen and vaginal atrium and an account of the techniques of surgical correction. In the early attempts at surgical correction, the vaginal space between the urethra and rectum was opened and packed with a wool tampon dipped in vinegar. This

VAGINAL AGENESIS/ Bates and Wiser

method of surgical correction was utilized until the method of inlay split-skin grafting was pioneered by Robert Abbe in 1898.⁵ McIndoe⁶ perfected the technique initiated by Abbe and increased its acceptability by emphasizing the advantages of ease of performance, low morbidity, excellent end result, and absence of mortality. Modern methods of vaginoplasty, including the technique we described, are modifications of the McIndoe operation.

Most of the vagina is formed by canalization of the caudal extremities of the fused müllerian ducts; the most cephalad portions of the müllerian ducts form the uterus and fallopian tubes. Dysgenesis of

the müllerian ducts form the uterus and fallopian tubes. Dysgenesis of the müllerian primordia results in varying degrees of abnormal uterine and vaginal development, and usually absence of both.⁷ Thus, uterine agenesis as a concomitant finding in vaginal agenesis is the rule rather than the exception.

Other congenital abnormalities frequently accompany vaginal agenesis.⁸ Approximately one-third of patients have abnormal kidneys as delineated by intravenous pyelography. These abnormalities range from renal agenesis of one kidney, fused kidneys, ectopia of one or both kidneys, and abnormalities of the collecting systems. Associated skeletal abnormalities occur in 12% of patients. Most of these affect the vertebral column causing scoliosis, kyphosis, and the Klippel-Feil abnormality.

Ovarian function is not altered in women with vaginal agenesis. Thus, secondary sexual development is neither delayed nor altered. Breast development and sexual hair growth occur at the expected time during adolescence, but menstruation fails to begin. Often, the diagnosis of vaginal agenesis is delayed until these young women (or their parents) become concerned about failure to menstruate.

Opinion varies among gynecologists about the appropriate time in a young woman's life to perform a vaginal construction. Some gynecologists advise their patients to wait until they are considering marriage to have the operation performed. We disagree strongly with this recommendation. We believe that a delay in performing the operation beyond the mid-teenage years (ages 15-17) results in poor psychosexual development of a woman affected with vaginal agenesis.

The normal human vagina serves dual roles. The vagina is the functional means of the human female's sexual expression and is a functioning part of her reproductive mechanism. As the adolescent female undergoes secondary sexual maturation, she becomes aware of her sexual desires and her means of sexual expression. The discovery of vaginal agenesis (by self-discovery or by clinical diagnosis) shatters her hopes of sexual expression and motherhood.

David et al⁹ reported the psychologic effects of vaginal agenesis in 17 women before and after surgical correction. Upon discovery of vaginal agenesis, these women voiced feelings of "shock," "depression," "confusion," "hysteria," and "a deep feeling of being different" (direct quotations). After diagnosis, three women ended their relationships with men and were unable to establish lasting heterosexual relationships. After a vaginoplasty was performed, these women were frustrated



Figure 3. This illustrates the result of the modified McIndoe vaginoplasty performed on the subject of this case report nine months after surgery. (Note the pigmentation of the vagina in this subject.)

by their inability to bear children, but all were able to develop healthy heterosexual relationships.

Masters and Johnson¹⁰ investigated the functional response of five women with vaginal agenesis who were managed by surgical vaginoplasty. They found that these women had lubrication of the vaginal wall by mucoid material within 30 to 40 seconds of sexual stimulation. Moreover, these women had normal excitement, plateau, orgasmic, and resolution phases of sexual function with the neo-vagina.

We conclude that the modified McIndoe vaginoplasty is an excellent technique for managing the young woman with vaginal agenesis. The procedure provides psychologic rehabilitation for a young woman who has no mechanism for sexual expression, and the procedure provides her with a functional vagina. We advocate early surgical intervention (age 15 to 17) to reduce the psychological handicap associated with vaginal agenesis and to enable a young woman to form healthy heterosexual relationships. ★★★

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A Look at the Peer Review Improvement Act of 1982

PATSY SILVER

AFTER MANY YEARS of controversy the Professional Standards Review Organization (PSRO) program has been repealed by Congress and replaced by a system outlined in the Peer Review Improvement Act of 1982.

The PSRO program, established under 1972 amendments to the Social Security Act, was beset by problems throughout its ten-year history. Difficulties with the law increased and objections to the program grew, and in December 1980 the American Medical Association's House of Delegates called for repeal of the program. The AMA's action reiterated the association's long-standing policy of support for a physician-directed system of medical peer review rather than a federally-directed program.

The medical profession was not alone in its perception of the program's deficiencies. Early in 1981 the Reagan Administration announced intentions to eliminate the PSRO program in keeping with a stated campaign objective to reduce burdensome, unnecessary and inefficient government regulations. The action also was consistent with the Administration's advocacy of competition in health care as a means of encouraging private enterprise to promote quality medical care at a reasonable cost and to initiate necessary review systems.

The Mississippi State Medical Association's House of Delegates, in May of 1982, also adopted a statement encouraging the elimination of all government direction of peer review programs, including PSRO. The MSMA's resolution, summarizing sentiments of physician groups across the nation, noted that "it is in the best interest of the medical profession and the patients served by the profession to ensure that patients receive high-quality medical care and that such care should be of appropriate duration and rendered in an appropriate setting at a reasonable cost." The resolution further declared that physicians are best qualified to determine quality of care, appropriateness of duration and setting, and reasonableness of cost, and remarked that "such determinations could be effectively and accurately made without government interference or regulation."

Last spring Congress began work on the Tax Equity and Fiscal Responsibility Act of 1982, which addressed, along with PSRO, a number of other medical-related issues. The PSRO-replacement legislation which was ultimately accepted by Congress (the Durenberger Amendment) had received the support of many medical leaders across the country, including the Board of Directors of the Mississippi Foundation for Medical Care, the state's PSRO. The Foundation's Board of Directors viewed the bill as a way to eliminate some weaknesses with the existing law and permit the state's peer review organization to operate more effectively.

Support for the new program has also been announced by the American Medical Association. Following action taken by the AMA House of Delegates just last month, the association reported that it will expand assistance to physicians and medical societies in assuming a leadership role in medical peer review. The AMA will work to strengthen portions of the new program, but will continue to seek modification of those mandatory elements which are not consistent with current association policy. The official statement noted that if those efforts at modification fail, the association will seek repeal of the new program.

Differences in the Laws

Basic differences between the old PSRO law and the new peer review act are in the matters of contracting, geographic areas, review mechanisms, and definition of the review organization's status under the Freedom of Information Act. While the new statute does not eliminate review of medical services under federal reimbursement programs, it does reduce some of the regulations and provide for some flexibility in the review process.

Exactly how the new law will be put into effect remains unclear, since enabling rules and regulations have not been developed and decisions on allocations have not yet been made. Until those details are spelled out, it will be difficult to determine exactly what effect the statute will have on the Mississippi Foundation for Medical Care, which

continues to function as the state's review organization. (Under the new statute, existing PSROs will continue to operate until the secretary of the Department of Health and Human Services designates a new review organization.)

The act replaces PSROs with Utilization and Quality Control Peer Review Organizations (UQCPROs) and gives the secretary of HHS the authority to contract with those organizations for the purpose of "promoting the efficient and economical delivery of health care services and of promoting the quality of services" for which payment is made under the Medicare program. In addition, state Medicaid agencies may contract with UQCPROs for utilization review.

A major departure from the old PSRO law is the provision that specific criteria of review contracts will be individually negotiated with each UQCPRO rather than mandated nationwide. Also, there is additional flexibility in determining which agencies or organizations are eligible for UQCPRO designation. The requirement that the review organization be non-profit has been removed.

Physician groups are to be given priority in contracting as the review organization. The law does not preclude a medical society from contracting as an UQCPRO, and some societies have expressed an interest in exploring the possibilities of bidding on contracts.

The term UQCPRO is defined as an entity which "is composed of a substantial number of licensed doctors of medicine and osteopathy engaged in the practice of medicine or surgery in the area" or an entity which has available to it the services of a sufficient number of physicians engaged in the practice of medicine or surgery, to assure the adequate peer review of the services provided by the various medical specialties and sub-specialties.

The number of review areas is expected to be reduced under the new statute, with the law presuming that each state will be designated as an UQCPRO area, thus creating 50 areas except in certain situations. The secretary may designate a local or regional area where the volume of review activity justifies the action, but the law's provision for consolidation of geographic areas is expected to produce less than the 194 review areas established under the old PSRO law.

Another provision of the new statute exempts UQCPROs from the Freedom of Information Act, thus helping to maintain the confidentiality of medical information. This provision clarifies the long debate over PSRO status as a federal agency for provisions of the Freedom of Information Act.

The statute includes a requirement that the review organizations make themselves available to the private sector. This is consistent with the MSMA's 1982 House of Delegates action, which called upon the Mississippi Foundation for Medical Care to reinforce its efforts to perform peer review on behalf of non-governmental third party payors. (At this time the Mississippi Foundation, according to a spokesman, is exploring the possibility of negotiating contracts with some private sector groups by responding in inquiries from these groups.) The MSMA's 1982 statement to the Foundation also conveyed two other concerns: that the Foundation should reinforce its efforts to educate the profession about its goals and that it should design enforcement proceedings for its peer review findings.

Regarding the question of cost containment or quality assurance, the new law is specific, as was the old law. A function of UQCPRO is to determine whether the services furnished are or were reasonably and medically necessary, whether the quality of services furnished meets professionally recognized standards, and whether the services furnished could be "effectively provided more economically on an outpatient basis or in a different type of health care facility." That wording differs from PSRO statutory language, which referred to "appropriate health care setting," and did not specify outpatient or different type of health care facility.

The review process is similar to the review conducted by PSROs, with the UQCPRO authorized to make conclusive determinations, notify the practitioner or provider of claim disapproval and provide an opportunity to discuss a negative determination, including appeal if necessary.

The statute authorizes UQCPROs to review virtually any and all services covered by Medicare. They may conduct pre-admission, concurrent and/or retrospective review, may examine the pertinent records of providers or practitioners where review is taking place, and may inspect the facilities where services are being provided. They may also conduct focused review. All review must apply professionally developed norms of care, diagnosis and treatment, and base determinations on typical patterns of practice in the region.

An UQCPRO may sanction a provider or practitioner from the Medicare program in cases of gross or flagrant violations of the obligation to furnish appropriate care. This process is similar to that used by PSROs and offers a right of appeal and judicial hearing. In addition, the new statute provides both civil and criminal immunity to individuals who provide information to peer review organizations in

situations where the information is related to the performance of review and the information is not knowingly false.

As mentioned earlier, the Mississippi Foundation for Medical Care will continue to serve as the state's review organization until the secretary of HHS enters into a new contract with the designated UQCPRO.

Membership in the MFMC is voluntary and now numbers in excess of 1600 members. The organization's leadership is provided by a Board of Directors which is composed of 20 physicians, one hospital administrator, one nursing home administrator, and one consumer. The Foundation's objectives are to assure that inpatient hospital care is provided only when, and to the extent, medically necessary and is of a quality which meets professionally recognized standards.

The organization is now operating under a practice pattern review plan similar to that which most other states use. Aberrant patterns considering volume, case mix, lengths of stay, readmissions, ancillary services, and surgery are identified from hospital discharge data. When deviations are observed which reflect a questionable pattern of care or utilization, additional records are screened. (In Mississippi each month the MFMC looks at some 1500 records. In 20% of instances the MFMC requests additional records or has a physician review additional records.)

In the previous two complete years, as a result of

the MFMC's monitoring, 15 hospitals have been removed from delegated review with records becoming subject to prepayment review and denial of payment for admissions or days judged by physician reviewers as unnecessary; sanction proceedings have been initiated toward eight physicians for substantial and persistent violation of obligation; 19 other physicians have been notified of potential violation of obligations and were being closely monitored; and 92 other physicians with aberrant utilization patterns, unusually high volume of admissions, unexplained long average lengths of stay, and high percent of readmission rates were targeted for close surveillance April 1982-March 1983.

When interventions have become necessary, they have, for the most part, produced an effect, according to an MFMC spokesman. In more than 60% of interventions, a change is noticed. In less than 5% of instances does the intervention process produce a negative response.

The leadership of the Mississippi Foundation for Medical Care views the new Peer Review Improvement Act as an expression of Congressional confidence in physician organization's ability to conduct peer review, according to a recent statement issued by the Foundation. That same statement invited suggestions for improving the review process, seen to be a permanent, though changing, entity considering today's economic dilemma and increased concern for cost containment in health care. ★★★

Mississippi Foundation For Medical Care in Review

J. T. DAVIS, M.D.

THE MISSISSIPPI FOUNDATION for Medical Care (MFMC), a physician sponsored and directed organization engaged in peer review of medical care, serves as the PSRO in the state. MFMC membership, which is voluntary, consists of 1600 physicians. The organization is directed by a Board of Directors, composed of 20 physicians, one hospital administrator, one nursing home administrator and one consumer. The board is elected by the membership. The composition of the board and the seven subsidiary committees reflects geographically and by specialty the physicians within the state. There are presently 65 physicians serving as members of the Board of Directors and on the various committees, and the majority of these are family practitioners.

The MFMC's activities with respect to inpatient hospital care seek to assure that the quality of care provided meets professionally recognized standards and hospital care is provided only when, and to the extent, medically necessary.

The MFMC believes that peer evaluation of a physician's practice pattern is an effective way to address and correct problems related to overutilization and inappropriate care. This approach is currently being used in most situations rather than case by case concurrent review and is proving to be less costly and has greater potential for sustained change through improved practice habits. The mechanism consists of data analysis, on site screening of records and peer review by MFMC physician committees. Aberrant patterns considering volume, case mix, lengths of stay, readmissions, ancillary services and surgery are identified from hospital discharge data.

MFMC staff registered nurses, experienced in screening medical records, review on site. The frequency and duration of visits depend on volume of cases or previously identified concerns, with each hospital visited annually. Records are selected from recent discharges and are screened for compliance with established standards of care, utilization criteria and documentation requirements. If no significant deviation is observed after screening 15 to 20 records, no further records of that physician are re-

This statement of objectives and functions of the Mississippi Foundation for Medical Care – PSRO recently appeared in an issue of The Magnolia State Family Physician, and is reprinted with permission.

viewed and no action is initiated. When deviations are observed which reflect a questionable pattern of care or utilization, additional records are screened.

When the deviations are numerous or serious, records are requested and reviewed by a MFMC physician committee. Communications of the findings are sent to the physician, hospital review committee and hospital governing body *as required by regulation*. Depending on the persistence and seriousness of the concern, either a time for voluntary correction is allowed or the review committee recommends that a peer review panel be convened to meet with the physician. The problems identified in his utilization or care and recommendations for change are discussed with him. If sufficient change is not observed within a reasonable time, the concern is referred to the MFMC Board of Directors for further actions. These actions may include exclusion from payment.

The attitude of the MFMC Board of Directors and committees is that of leadership and education, offering every opportunity for improvement before penalties are recommended. In most situations communication of concern has resulted in improvement. Recently MFMC arranged with the University of Mississippi Medical Center for continuing medical education for physicians, based on identified need.

At any point in the monitoring process a physician whose records are reviewed by MFMC may request that the Foundation convene a panel of his peers to meet with him to discuss medical care concerns.

Since the MFMC review, as well as other quality assurance programs, is based on record review it is important that physicians maintain good records. The records should clinically indicate the need for hospitalization and the need for services and care available only in an acute care hospital. When non-medical reasons or socio-economic factors influence the admission or stay the facts should be documented

Dr. Davis is medical director, Mississippi Foundation for medical care.

in the record and supported by social service documentation. The clinical record should reflect efforts by the attending physician to select a differential diagnosis and limit services to those necessary to establish a diagnosis and assist in appropriate therapy. The record should document attention to abnormal findings and demonstrate good professional judgment in the evaluation and treatment process. Progress notes should be legible. The entire record (history, physical, progress notes, diagnostic findings, therapy and discharge summary) should reflect consistency between the reason for admission, evaluation, treatment and final diagnosis. Good documentation need not be verbose but should present a clear, concise, accurate and professional description of the patient's condition, assessment of findings, plan of care and response.

It is essential that every physician understand that the patient's hospital medical record is a legal document which is completed at the time of discharge and cannot legally be altered or added to, other than completion and inclusion of the discharge summary. Accurate documentation is not only essential for the welfare of the patient and a source of information for the physician in the future, but serves as a protection to the physician in case of litigation. The physician reviewer makes his determination based on the contents of the medical record and cannot be influenced by assumptions, on his part, in making a determina-

tion.

Looking to the future, from the Medicare perspective, *peer review is here to stay* as reaffirmed by Congress in the recent enactment of The Peer Review Improvement Act of 1982. This Act will replace the PSRO legislation and will be in effect when regulations are published and agreements are negotiated in each area. The PSRO program will continue until that time. This Act reflects the confidence of Congress in the physician organizations to conduct peer review. The new Act simplifies the review process; allows for negotiation of specific objectives for impact; strengthens confidentiality to protect review findings and determinations from discovery by outsiders; and encourages review in the private sector.

Realizing that very few things are perfect, progress toward perfecting a better process in peer review has always been an objective of the Foundation. The Foundation is receptive to suggestions for improving the review program.

With today's economic dilemma and increased pressure for cost containment a parting question for thought is, "Can the attending physician justify the cost to the patient for hospitalization, services and treatment and is the fee for service commensurate with the time, effort and clinical ability required?"

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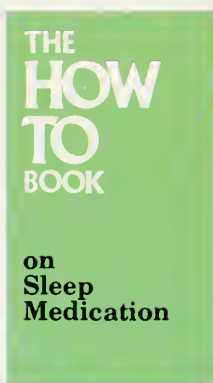
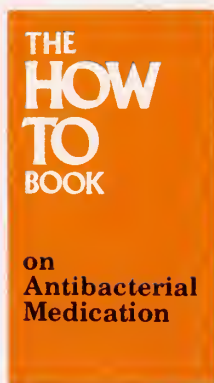
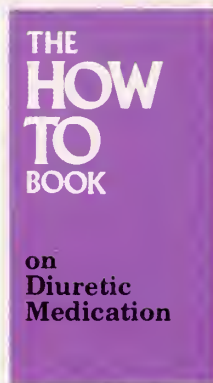
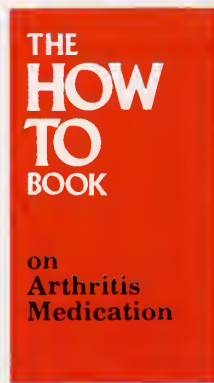
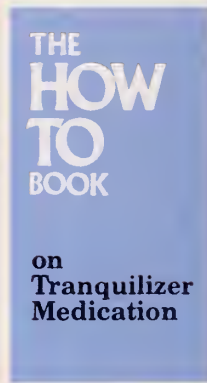
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References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

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PROFILES

William Boyce White, M.D. Trustee, District 7

William Boyce White, M.D., a member of the Mississippi State Medical Association Board of Trustees since 1978, currently serving the Board as vice-chairman. He previously held the post of secretary. For years he has been an active member of the MSMA, serving on various councils and committees and as delegate to the House of Delegates.

Dr. White says he has always enjoyed the opportunities he has had to work in the state medical association. He has also been an active member of South Mississippi Medical Society, and formerly served as president and secretary-treasurer of Jones County Medical Society.

In an interview with JOURNAL MSMA, the Laurel family physician related his admiration for the late Dr. John Tate and described the influence this role model had in determining his own choice of careers.



Dr. Boyce White, pictured as he attended a banquet during the MSMA Annual Session.

When he was growing up in the north Mississippi community of Ripley, Dr. White stated, he had very high regard for Dr. Tate, whom he considers the archetype of the country doctor. He made frequent house calls and often would sit with the family in the living room or around the kitchen table. He knew his patients personally and shared their lives, and he was an admirable individual. The influence of that man eventually led Boyce White to study medicine and to become a family physician.

Dr. White has practiced in Laurel since 1962. He received his undergraduate education at Northeast Mississippi Junior College, Millsaps College and the University of Mississippi. He attended the University of Mississippi School of Medicine, receiving his M.D. degree in 1957. After interning at Confederate Memorial Medical Center in Shreveport, he served four years as flight surgeon in the U.S. Navy.

Dr. White is a diplomate of the American Board of Family Practice and is a charter fellow of the American Academy of Family Physicians. He has served as medical director of the Ellisville State School, as consultant at South Mississippi State Hospital in Laurel, and as assistant professor in the department of family medicine, University of Mississippi School of Medicine. He is a member of the American Medical Association, Southern Medical Association, and of Flying Physicians Association.

When he is not busy with his practice, Dr. White enjoys reading, particularly non-fiction. He also writes for pleasure, an activity which provides, he says, an outlet for organizing and expressing his thoughts. Dr. White and his family are active members of the First Presbyterian Church of Laurel, where he has served as a deacon and elder.

Dr. White looks forward to each opportunity to spend time with his children. Ellen Brown White, his wife of 24 years, passed away early in 1982. Their children are: Warren, a graduate of North Texas State University, a professional musician now touring with the Ice Capades; Catherine, a senior psychology major at Ole Miss; and Susan, a sophomore at Ole Miss, majoring in accounting. The family will soon include another physician, as Catherine is engaged to a young man who is now a senior at Vanderbilt University School of Medicine.

Fourth in a Series featuring members of the MSMA Board of Trustees

George L. Arrington, Jr., M.D. Trustee, District 6

George L. Arrington's early exposure to the medical profession as the son of Dr. G. Lamar Arrington undoubtedly influenced his own choice of careers.

The elder Dr. Arrington's great interest and long years of participation in the activities of the Mississippi State Medical Association might also have set an example and generated a desire on the part of his son to serve the association in various leadership posts. The younger Dr. Arrington was elected to the MSMA Board of Trustees in 1980, after serving on numerous councils and committees.

His father's tenure on the MSMA Board of Trustees may be among the longest records of service in the association's 125 year history. Dr. Lamar Arrington was first elected to the Board of Trustees in 1941 and served continuously until 1951, when he was elected to the post of president-elect. In 1952 he was inaugurated MSMA president. Several years later, in 1958, he was re-elected as a trustee and served continuously for an additional ten years.

Dr. George Arrington has practiced in Meridian since 1969. He received the B.S. degree from the University of Mississippi and the M.D. degree from Tulane University College of Medicine. After interning at Charity Hospital in New Orleans, he completed a one-year fellowship in general surgery at Ochsner Foundation Hospital. He also completed three years of residency training in ear, nose and throat and facial plastic surgery at Charity Hospital in New Orleans.

He served two years in the U.S. Air Force and for one year was consultant for ear, nose and throat for



Dr. George Arrington is a regular participant in the MSMA Fishing Rodeo each year. He and his wife, Nancy, are pictured as they returned from the deep sea fishing trip last year.

the Southeastern Air Force Hospitals.

Dr. Arrington is a diplomate of the American Board of Otolaryngology. He is the founder of the Meridian Ear, Nose and Throat Clinic and is co-founder and president of the Board of Directors, Meridian Speech and Hearing Center.

He is a former president of the Mississippi Ear, Nose and Throat Association and of the Mississippi Society of Reconstructive and Facial Plastic Surgery. Dr. Arrington has served as an assistant councilor to the Southern Medical Association and has also served as state councilman for the Association of Southern Railroad Surgeons. He is a member of East Mississippi Medical Society and the American Medical Association, and recently completed a two-year term as Chief of Staff of Jeff Anderson Memorial Hospital in Meridian.

Dr. Arrington lists hunting and fishing as his favorite interests. He is a regular participant in the MSMA fishing rodeo conducted during the annual sessions in Biloxi. He also enjoys playing golf, and was recipient of a trophy during another of the association's annual events, the golf tournament.

Dr. Arrington is married to the former Nancy Hobart of Meridian. They have four children, two daughters who are attending the University of Mississippi, and two sons who are students in Meridian.



The President Speaking

Just Down the Road

SIDNEY O. GRAVES, JR., M.D.
Natchez, Mississippi

The Interim Meeting of the American Medical Association was held in Miami Beach, Florida, December 5-8, 1982. This was an interesting meeting, even though not exactly a landmark event. It was more a meeting of premonitions. One got the feeling that a lot was getting ready to happen, "just down the road."

A spirit of elation prevailed at the meeting, since the House of Representatives had just voted to defeat the FTC-Broyhill Amendment. We were very confident that the Senate would act favorably and this FTC problem would be settled. As you all know by now, this did not happen. The President used his personal clout and the news media came out strongly against our position. As a result, we lost in the Senate. With a new Congress that will probably be less favorable to medicine, I believe we are in real trouble, "just down the road."

Probably the subject of most concern to practicing physicians that was discussed at the Interim Meeting was relative to the Joint Commission on Accreditation of Hospitals (JCAH). The Board of Commissioners of JCAH, which is composed of 22 members, seven of whom are appointed by the American Medical Association, approved draft revisions in several chapters of the *Accreditation Manual for Hospitals*. This draft is scheduled to go to more than 3,000 individuals and organizations, including all JCAH approved hospitals, for comment. At this Interim Meeting, the House of Delegates recommended that the proposed revisions be widely disseminated for comment. The comments will be compiled and received for approval by the Board of Commissioners in April 1983. Among the changes that are important to us are:

1. Retitling the chapter "Organized Staff."
2. Making all references to staff consistent with the title, with the use of the term "Organized Staff."
3. Stating that "The Organized Staff includes fully licensed physicians and may include other *individuals* who also qualify for clinical privileges and/or *licensed for independent provision of patient care services*."
4. Deleting all specific references to oral surgeons and podiatrists in the standards.
5. Clarifying the language on the delineation of the privileges.
6. Defining the composition of the executive committee of the Organized Staff.

All of these changes are pertinent, but I call your attention particularly to number three. I do not need to elaborate on the issues that will be raised by the opening of this Pandora's box. We should make our views on this matter known.

The copy of the proposed revisions being sent to JCAH approved hospitals has an evaluation form in the back on which individual standards can be checked as being acceptable or not acceptable. There's also space to write in comments about the proposed standard interpretation, or required characteristic. I strongly urge each and every one of you to seek out your hospital administrator and get him to furnish you with a copy of the evaluation form so that you can express your views on these proposed standards. Unfortunately, we only have until February 4, 1983 to respond to the Department of Standards, Joint Commission on Accreditation of Hospitals, 875 North Michigan Avenue, Chicago, IL 60611.

I urge you to act in haste in an effort to avoid something that is surely going to happen "just down the road."

★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXIV, Number 1

JANUARY 1983

Keep It in the Family

PSRO — Far from perfect, but it is the best we have at present and it is still run by Mississippi physicians.

As long as government dollars are spent on health care there will be monitoring. Mississippi Foundation for Medical Care is a democratic organization, controlled by a board of directors, who are elected by the membership. Membership is open to any physician who is licensed to practice in Mississippi.

If you have complaints or suggestions, please send them to the board. They will be considered, but let's keep it all "in the family." It serves no useful purpose to air our grievances before our congressmen who have little knowledge of the situation.

The Foundation welcomes constructive criticism and it needs input from all our members. My point can best be made in a letter written by Dr. Lamar Weems, president of MFMC, to one of the membership, and it appears below.

"Dear _____: Thanks for sending me copies of your response to the MFMC review physician's critical review of a few of your charts. I understand your consternation because I know that the review process is not perfect as we exercise it and because I resent, as much as anybody, the intrusion of any external authority into my own affairs. On the other hand, practically all of us could run a tighter hospital practice than we do in regards to documentation, utilization of services, necessity for admissions and length of hospital stay. We practically always do pay more attention to cost saving measure when we know that our charts will be audited.

"In the past few years, I have agreed to serve in various capacities with the Foundation on the basis of a couple of assumptions. It is my belief that some surveillance mechanisms must be in place when public money is being spent. The other assumption is that the monitoring of medical care will likely be less onerous in the days ahead, and more effective, if physicians are in charge of it. Of course, nurses and physicians who perform reviews can be expected to make mistakes because they are not privy to all of the

factors at play in the care of each patient. Furthermore, the techniques of performing these reviews are still rather primitive. However, mechanisms of appeal are available if mistakes are made. More importantly, all of us who engage in this work should be receptive to criticism and suggestions which may improve our performance.

"In that regard, I appreciate your view of your encounter with the MFMC reviewers. I must chide you, however, for sending copies to various political figures. It comes across to me as a vindictive act with very little constructive intent. None of them will truly understand this episode. Sharing this argument with them only serves to politicize an activity which we would be well advised to keep out of the political arena as much as possible. After all, most of the questions involved here are professional ones and can best be resolved by dispassionate interchange among professionals. To that end, I am *not* sending a copy of this letter in rebuttal to any of the public officials who received your comments. I will try to see that your grievances receive careful attention and I apologize in advance for any mistakes that may have been made. However, you shouldn't expect me or the others involved to be intimidated by the political threat which is implicit in your sending copies of this material to your senators and congressmen. When the level of professionalism in peer review degenerates to the point that we must settle our differences before a tribunal of politicians, I, for one, will not accept a position of responsibility."

W. MONCURE DABNEY, M.D.
Editor

Guest Editorial

Will the Fox Guard the Hen House?

This issue of JOURNAL MSMA contains a review of the history and of the activities of the Mississippi Foundation for Medical Care. The article is timely. Events are beginning to unfold which will test the

resolve of physicians in Mississippi to retain a leadership role in the review process.

Peer review has traditionally been espoused by organized medicine. However, lacking effective and legally safe mechanisms to enforce adherence to standards, physicians in the past have generally reacted to only the most flagrant abuses.

Things have changed. A substantial proportion of payments to physicians and to hospitals now comes by way of third party carriers. The people who administer these programs, supported by their subscribers and by taxpayers, are demanding accountability for expenditures on health care. These demands are backed by the authority to withhold payment. Admittedly, physicians can escape most of this intrusion into their professional affairs by refusing to accept third party payments. This option will not be a viable one for most of us in the future.

We must, of necessity, accept the fact that someone will audit the care which we provide. This review activity will not be all bad. In fact, it may be possible to turn it to the highest purpose which we serve, which is to improve the quality and availability of medical care for our patients.

In my opinion, this objective can only be met if we physicians are able to retain the prerogative of monitoring our own profession. There is no certainty that we will be permitted to do that. Some cynics liken it to putting a fox in charge of the hen house. Some of our own members still cling to the nostalgic view that, by resisting, surveillance of their professional activities can be avoided. So, the crisis is upon us. To restate a worn cliché, "we can either do it or they will do it for us."

The following is part of a letter which we sent to members of the Mississippi Congressional delegation which publically states the position of the leadership of the Mississippi Foundation for Medical Care:

Physicians in Mississippi generally concede that, when public money is spent on health care, some surveillance mechanism must be in place to assure that the quality of care which is purchased is acceptable and that waste is minimized. This concession was not readily embraced because physicians prize their professional independence and tend to resist intrusion into their relationships with their patients. Nevertheless, the leadership of organized medicine in Mississippi supported the implementation of the PSRO by the Mississippi Foundation for Medical Care in 1974 in the belief that physicians should provide leadership in review activities. Today the organization is composed of 1500

physicians and retains the support of the Mississippi State Medical Association in spite of the stresses which are inherent in peer review.

We have learned a great deal from our experience in the PSRO peer review mechanism. We have better insight into the quality of care which citizens of this State are receiving and we are more aware of the importance of economy in the health care delivery system. In many ways, the responsibility for review is onerous, but we strongly feel that it should be retained by physicians. We believe that, in the Mississippi Foundation for Medical Care, we have created an effective and respected review mechanism. However, we have encountered some encumbrances in the form of excessive red tape, along with inefficient and expensive appeal mechanisms for denial of payment and sanction. With relatively minor changes in the law, we could do a better job. We would like to call your attention to pending legislation (S2142). This legislation (the Durenberger Bill) which has been passed by the Senate would correct most of the weaknesses which we perceived in existing law. We urge your support of this legislation along with adequate funding for medical review. We pledge our continued efforts to promote the highest quality care at the lowest reasonable cost of our citizens.

This legislation was passed. At the present time, MFMC is on firm footing financially and enjoys the faithful participation of an expanding cadre of physicians. Even as the program prospers, however, we hear a rising chorus of complaints. On the one hand, one would expect to hear complaints when penalties are being assessed. Complaints may be a sign of effective action by the Foundation. On the other hand, many of the complaints are legitimate because the review process as we exercise it is not perfect.

We need to communicate. This issue of JOURNAL MSMA is a good opportunity to reopen the lines. Another opportunity will occur next spring at the annual meetings of the Mississippi State Medical Association and the Mississippi Foundation for Medical Care. We have never had a freewheeling, desk-pounding, name-calling debate at one of these Foundation meetings. I invite the dissidents among us to come to the meeting and let's have one.

W. LAMAR WEEMS, M.D.
Jackson, MS

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

MEDICAL ORGANIZATION

Board of Trustees Holds Fall Meeting

MSMA's Board of Trustees held its regular fall meeting in Jackson on December 2 and handled a full agenda of business.

Primary items coming before the Board for action were the 1983 association budget and recommendations on health legislation before the Mississippi Legislature which will convene for a three-month session in January.

The Board approved a 1983 budget of \$1,206,450 to include a projected \$415,000 in AMA dues transmittals. The Board noted a continued increase in MSMA membership with over 2,000 members on the roll in 1982.

The Board reviewed a malpractice reform program that will be presented to the 1983 Regular Session of the Mississippi Legislature. An extensive public and professional educational program will be conducted on behalf of the program. The Board also reviewed the association's support for legislation to extend Medicaid coverage to medically needy married pregnant women and their children, to require child restraint mechanisms in automobiles, to strengthen the state's DWI law and to conduct a statewide medical examiners system headed by a forensic pathologist.

The Board also acted to approve promulgation of a group health insurance program for members and their employees and to review recommendations of a Committee to Study MSMA Reorganization.

Reports were also considered on activities of the Mississippi Medical Political Action Committee, Medical Assurance Company of Mississippi and Mississippi Foundation for Medical Care. Planning for the MSMA and Auxiliary seminar on "Critical Health Issues in the 80's" and a political action workshop to be conducted in Jackson, March 5-6, was also reviewed and the status of association's new public relations program titled "CommuniCare" was discussed.

Attending the Board meeting were: Ellis M. Moffitt, M.D., Jackson, chairman; W. Boyce White, M.D., Laurel, vice chairman; Roy D. Duncan, M.D., Pascagoula, secretary; Virginia S. Tolbert, M.D., Ruleville; W. Joseph Burnett, M.D., Oxford; William C. Gates, M.D., Columbus; William B. Hunt, M.D., Grenada; James O. Manning, M.D., Jackson; David R. Steckler, M.D., Natchez;

Sidney O. Graves, Jr., M.D., Natchez, president; Whitman B. Johnson, Jr., M.D., Clarksdale, president-elect; R. Faser Triplett, M.D., Jackson, immediate past president; J. Elmer Nix, M.D., Jackson, secretary-treasurer; Carl G. Evers, M.D., Jackson, speaker of the House of Delegates; James C. Waites, M.D., Laurel, vice speaker of the House of Delegates; W. Lamar Weems, M.D., Jackson, delegate to AMA; Charles L. Mathews, Jackson, executive director; H. Cody Harrell, Jackson, assistant executive director and controller; Burke C. Murphy, Jr., Jackson, assistant executive director and legal counsel.

Collaborative Effort Produces Maternal/Infant Care Project

Indigent maternity and infant patients in four Delta counties are getting an \$800,000 health care boost through collaborative efforts of concerned agencies, private physicians, and hospitals who took an innovative approach to providing access to health care.

The Mississippi State Department of Health secured a \$400,000 grant from the Department of Health and Human Services national maternal and child health office to pay hospital reimbursement costs. Concurrently, Mound Bayou Community Hospital and Delta Health Center, Inc., applied for and received \$400,000 from the DHHS Regional Office of Primary Care to reimburse physicians for delivery services and for medical care for acutely ill infants. The State Department of Health will coordinate both grants.

A task force composed of representatives of the National MCH office, the Atlanta regional primary care office, and the Mississippi State Department of Health recommended the dual application for grant funds to be used in Bolivar, Coahoma, Sunflower, and Washington Counties.

Federal health officials who foresaw a reduction in federal health care funding for that area organized the task force to study accessibility to existing resources for indigent maternity and infant patients.

Through a series of meetings with private health care providers in the four counties, the task force found that the primary barrier to development of a system of health care for indigent maternity and pediatric patients was the lack of funds to reimburse for inpatient services in local hospital.

Participants in the series of hearings expressed

concern for the medically underserved. But hospital administrators, with a heavy load of Medicaid patients and an eye to fiscal reality, said that if the local hospitals had to absorb more no-pay or low-pay patients, those hospitals would face severe financial problems.

The task force recommended seeking federal funds to establish a system of care using existing resources. The money became available September 1 and is expected to serve 750 of the estimated 1,000 potentially eligible patients in a 12-month period.

This project promotes early entry to prenatal service, risk-scoring at each prenatal visit and referral to the appropriate level of care through use of the Hollister record to provide a uniform system for risk-scoring and exchange of information, entry into family planning services for the delivered patient, well child care for the newborn, special supplemental foods under the WIC Program, and public health staff follow-up for patients who failed to keep medical appointments.

Most outpatients will get health care services at existing public clinics, with inpatient services contracted through the private sector.

This cooperative pooling of resources and efforts among agencies and private providers may represent a model health care system for providing perinatal health services to low-income pregnant women and their infants.

"The project is a good example of what can be accomplished when concerned agencies and individuals cooperate to meet a need," stated Dr. Donald R. Ellis of Clarksdale, one of the physicians involved in the project.

Medical Center Hosts Thoracic Society Seminar



Dr. James Holmes, right, of Wiggins, participated in the Mississippi Thoracic Society's annual seminar and Boswell Lecture at the University of Mississippi Medical Center. Among others in attendance was Dr. George McMullan, Jr., center, of Jackson. Dr. Gvrk Sharma, left, from the Veterans Administration Medical Center in West Roxbury, MA, was among guest faculty for the course, co-sponsored by the Mississippi Lung Association and the Medical Center.

Pediatrics Academy Meets at UMC



Tupelo physician Dr. William Hilbun, Jr., at right, served as program coordinator during the annual meeting of the Mississippi Chapter of the American Academy of Pediatrics at the University of Mississippi Medical Center in Jackson. With him is Dr. Charles Tharp, left, also of Tupelo. The two-day program was co-sponsored by the University of Mississippi School of Medicine Department of Pediatrics and the UMC Division of Continuing Health Professional Education. Dr. Alfred Brann from Emory, the first director of the UMC newborn center, gave the 1982 Claud L. Batson Memorial Lecture.

Dr. Achord Named President-Elect, American College of Gastroenterology

Dr. James Achord, professor of medicine and director of the digestive diseases division at the University of Mississippi Medical Center, has been named president-elect of the American College of Gastroenterology.

He has been a fellow in the college since 1970 and has served on its board of governors, and the program and finance committees. He will assume the presidency of the college in October, 1983.

Dr. Achord was professor of medicine and associate dean of clinical affairs at East Tennessee State University College of Medicine before he was appointed to the Medical Center faculty.

A graduate of Emory University School of Medicine, he also took residency training at Emory. He is past president of the gastroenterology section of the Southern Medical Association and past chairman of the committee on concurrent care of the American Society of Internal Medicine. He is a fellow in the American College of Physicians.

His principal research interest is the pathology and physiology of the small bowel and liver and has

contributed some 30 articles to medical and scientific journals.

Dr. Michael LeBlanc Receives AAP Young Investigator Award

A newborn specialist at the University of Mississippi Medical Center has received the Young Investigator Award of the American Academy of Pediatrics, Section on Perinatal Pediatrics.

Dr. Michael LeBlanc, assistant professor of pediatrics, received the award and presented the paper on which the award was based at the academy's annual meeting in New York.

He reported on his research dealing with babies who have polycythemia. "There is some evidence to suggest that this condition at birth is a precursor to later problems such as neurological abnormalities," LeBlanc said, "but we don't really understand the precise physiological mechanisms."

LeBlanc's research, reported in the October, 1982, issue of the *Journal of Applied Physiology*, was a study to determine whether polycythemia interfered with the efficiency of oxygen transport to the body's tissues and the consumption of oxygen by the tissues.

"About one baby a week here at the Medical Center has polycythemia, so it would be our advantage to understand as much about it as we can," he said.

Mississippi Scientists Discover New Hemoglobin

Mississippi scientists have discovered a new hemoglobin in a blood sample from a prisoner at the Mississippi State Penitentiary in Parchman.

Named "hemoglobin Parchman" in the traditional manner of naming new hemoglobins for the location of their discovery, the molecule for the first time, offers geneticists proof that the "double crossover" of unlike genes occurs in humans. The discovery also gives scientists more information about what turns genes "off and on," one of the great puzzles of the life process.

The findings of Dr. Junius G. Adams, III, associate professor of medicine (research) at the University of Mississippi Medical Center (UMC) in Jackson and director of the hemoglobin lab at the Veterans Administration (VA) Medical Center, have been published in the October 15, 1982, issue of *Science*

magazine. His co-investigators are W. Tully Morrison, research technician, and Dr. Martin Steinberg, UMC professor of medicine and VA hematologist.

Adams' lab at the VA is one of only a few in the country capable of extensive analysis of hemoglobin. Specialized equipment can detect an abnormal or variant hemoglobin such as the one which characterizes sickle cell trait. Adams examined the prisoner's blood sample to check for the sickle cell hemoglobin. Instead, he found the new hemoglobin, not in itself especially noteworthy.

But analysts of the sequence of amino acids revealed that the material from two unlike genes had exchanged not once, which is rare, but twice. The double crossover had been demonstrated in bacteria but never in man. Unlike genes exchanging material accounts for the creation of new genetic information, Adams said. "It's the basic mechanism of evolution."

The genes which coded for one protein in the hemoglobin molecule crossed over to mingle with the genes which coded for a different hemoglobin protein. The new hybrid with an entirely new arrangement of genes told the team something about turning genes "off and on" that no one knew before.

The two basic types of adult hemoglobin molecules differ only in their protein composition, Adams explained. Hemoglobin A has alpha and beta chains of protein and accounts for 97 per cent of all hemoglobin in the adult human body. Hemoglobin A2 has alpha and delta chains. Only about two per cent of the hemoglobin in the adult body is of the second type.

"Clinically, and especially in the study of sickle cell disease, it would be worthwhile to know how to make all hemoglobin have delta protein because the trait for sickle cell is on the same set of genes which code for beta protein," Adams said.

"And perhaps, we could do that if we could learn what turns off the gene which codes for delta protein. Obviously something does because there's so little of it."

What Adams and his team found out was that they had been wrong in their previous assumption, shared by most geneticists, about the location of the portions of the gene which diminished delta production.

In the hybrid hemoglobin, a portion of the gene previously believed to be responsible for controlling the production of delta protein, was replaced by the corresponding portion of the beta chain gene. But the hybrid protein was produced at rates comparable to that of the delta chain, leading to the inevitable conclusion that other portions of the genetic material control delta protein production.

Student Tuition Funding Affected by HPSL Program Rules

The University of Mississippi School of Medicine, along with a number of other medical schools across the nation, faces the prospect of losing loan funds under the Health Professions Student Loan program.

The situation results from recently published U. S. Public Health Service rules amending existing regulations governing the student loan program, and the requirements are expected to have a definite impact on medical school enrollment.

Under the new rules, participating schools have until March 31, 1983 to establish a loan delinquency rate of not more than 5% or have loan funds cut off. The rules also require that schools maintain that rate each succeeding March 31.

At the University of Mississippi the delinquency rate already has been reduced. Strong efforts to collect on student loans produced a 9% delinquency rate, according to Dr. Carl Evers, associate dean. It is unlikely, however, that the rate can be improved to meet the requirement, he stated.

"We have considerable concern for our students," he said, explaining that students are facing increased tuition and diminishing sources of funding. Although the University's tuition is not as high as that of some schools, the student population generally is less affluent and therefore more in need of loan funds, he stated.

Dr. Evers pointed to the cutting off of capitation grants, the reduction in research grants, the high interest and lack of availability of commercial loans and rising tuition across the country as factors which already affect medical school students. Some medical schools, when considering applicants for admission, are placing increasing emphasis on prospective students' ability to pay. Some states, he said, are setting up their own loan programs and issuing bonds to guarantee loans as ways to deal with the situation.

The failure of some schools to make a serious effort to collect on loans led to the problem of excessive defaults. But many people in medical education believe the new requirements are an overreaction to the problem. The 5% delinquency rate is considered by many to be an unrealistic goal, and Dr. Evers pointed out that the HPSL program is the only loan program that is demanding such a rate.

The new requirements also define a delinquent loan as one which is 30 days past due. Some proposals, including that of the American Medical Association, would have considered a loan delinquent when

it became 60 to 90 days past due.

For those schools which retain eligibility for HPSL funds, the amended rules require that they establish monthly repayment schedules with borrowers, include a loan acceleration clause in their promissory notes, join credit bureaus and notify them of all delinquent accounts, use collection agents, and if appropriate, file civil lawsuits to recover money owed.

Medico-Legal Brief

M.D. Review Necessary For P.A. Services

The patient, a 44-year-old female, visited the Emergency Department of the Naval Regional Medical Center (NMRC) at the Philadelphia Naval Base with symptoms of fever, nausea, vomiting, and headache. She was examined by a physician assistant, who performed an abbreviated neurological exam which revealed photophobia but no nuchal rigidity. He diagnosed flu syndrome and prescribed Fiorinal and Tylenol, and instructed the patient to return if she was no better. During this visit, the patient was not examined by any physician, nor was her chart reviewed in any aspect by a physician.

Two days later, the patient returned to the Emergency Department in a wheelchair, unable to walk, still complaining of severe headache. She again saw the same physician assistant, who referred her to the Emergency Department physician. The physician performed a neurological exam and made the diagnosis of headaches, etiology unknown, and sent the patient home.

Several hours later the patient's husband again brought her to the Emergency Department where the same physician then diagnosed intracerebral hemorrhage and made arrangements for transfer to a Philadelphia hospital. There an arteriogram showed a large subdural hematoma and right posterior communicating artery aneurysm. A right frontoparietal craniotomy was performed with evacuation of a right subdural hematoma and clipping of the aneurysm. Postoperatively the patient did poorly and never regained consciousness. Two days later she went into respiratory failure, developed cardiac arrhythmia and died.

The patient's husband subsequently brought suit

(continued on page 30)

PERSONALS

GENE BARRETT of Jackson has been certified as a diplomate of the American Board of Orthopaedic Surgery.

HARRIS GUY BARRETT of Pascagoula recently was named a diplomate of the American Board of Family Practice.

WILLIAM BATES of UMC recently was visiting professor at the University of Oklahoma ob-gyn department and was guest lecturer for the Oklahoma City Obstetrical and Gynecological Society.

TOM E. BENEFIELD, JR. of Gulfport has been named president of the Tulane Medical Alumni Association.

RONALD T. BRUNI of Gulfport has been recertified by the American Board of Pediatrics.

ROBERT T. CATES and THOMAS M. DAVIS announce their association and the opening of Cates Plaza Clinic Family Care Center in Ridgeland.

JOHN D. COFFEY, JR. of Natchez has been recertified by the American Board of Pediatrics.

THOMAS M. DAVIS of Ridgeland has been recertified as a diplomate of the American Board of Family Practice.

Radiology Associates of Natchez (R. L. BROWN, WALTER T. COLBERT and JAMES G. KRESTENSEN) announce the association of FRED G. EMRICK for the practice of radiology.

KARL HATTEN of Vicksburg is chairman of the Vicksburg area "Gift of Life" campaign of the Kidney Foundation of Mississippi.

BOBBY HEATH of UMC presented papers at the recent Southeastern Pediatric Cardiology Society meeting in Seal Island, Georgia.

WILLIAM C. HOPPER, JR. of Gulfport was a keynote speaker for the First International Medical and Surgical Conference held at the Central Medical University of Quito, Ecuador, South America, and presented papers on topics in children's orthopedics.

LEROY HOWELL of Starkville has been recertified as a diplomate of the American Board of Family Practice.

KEN C. JONES of Jackson recently attended a course in laser treatment of glaucoma at Emory University in Atlanta.

HERBERT LANGFORD of UMC recently was speaker at a symposium on "Intercontinental Hypertension" in Molokai, Hawaii.

W. G. McDONALD of Brandon has been named a fellow of the American Academy of Family Physicians.

LYNN B. MCMAHAN of Hattiesburg presented a paper at the Welsh Cataract Congress held recently in Houston, Texas.

DON Q. MITCHELL of Jackson has been named president-elect of the Medical Alumni Chapter of the University of Mississippi Alumni Association.

JOHN MORRISON, JAMES MARTIN, RODNEY MEEKS and PATRICIA NORMAN of UMC presented papers at the recent meeting of the National Perinatal Association in Dallas.

MARCELENE JENKINS O'NEAL of Greenville has been recertified by the American Board of Pediatrics.

ONEY C. RAINES, III of Gulfport was recently elected chairman of the Mississippi Section of the American College of Obstetricians and Gynecologists.

FRANCIS J. SELMAN of Pascagoula has been named chief of staff at Singing River Hospital. Other officers are GLYN R. HILBUN, chief of staff-elect; and JAMES L. STITH, secretary-treasurer.

THOMAS R. SINGLEY of Pascagoula has been named vice-chairman of the Mississippi Section of the American College of Obstetricians and Gynecologists.

C. RANDOLPH TILLMAN of Natchez was guest speaker at a recent meeting of the Lions Club of Vidalia, Louisiana.

JERRY W. WELCH of Laurel announces the association of MINA CHUDGAR-NAYAK in the practice of obstetrics and gynecology.

WILLIAM WIENER of UMC spoke at a recent meeting of the Delta Medical Society.

WINFRED WISER of UMC was an examiner for the American Board of Obstetrics and Gynecology in Chicago in November.

NEW MEMBERS

BOND, FLOYD P., Jackson. Born Mobile, AL, July 9, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned University Medical Center, Jackson, one year; ob-gyn residency, same, 1971-74; elected by Central Medical Society.

BRADSHAW, FREDERICK J., III, Greenwood. Born Conquille, OR, May 26, 1937; M.D., University of Pennsylvania School of Medicine, Philadelphia, 1963; interned Hospital of the University of Pennsylvania, Philadelphia, one year; anesthesiology residency, Los Angeles County-University of Southern California Medical Center, Los Angeles, 1968-1970; elected by Delta Medical Society.

BRADSHAW, JOYCE J., Greenwood. Born Singapore, Aug. 27, 1938; M.D., Loma Linda University School of Medicine, Loma Linda-Los Angeles, CA, 1966; interned Los Angeles County-University of Southern California Medical Center, Los Angeles, one year; pathology residency, same, 1967-69; pathology residency, Wadsworth V.A. Medical Center, CA, 1969-72; elected by Delta Medical Society.

CHEVIS, BERTIN C., Bay St. Louis. Born Bay St. Louis, MS, Jan. 21, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned University of South Alabama, Mobile, one year; family medicine residency, University Medical Center, Jackson, 1980-82; elected by Coast Counties Medical Society.

CLARK, ROBERT E., Jackson. Born Meridian, MS, Dec. 19, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned Lloyd Noland Hospital, Fairfield, AL, one year; medicine residency, same, 1978-80; nephrology fellowship, University Medical Center, Jackson, MS, 1980-82; elected by Central Medical Society.

CROMARTIE, ARTHUR D., Hattiesburg. Born Washington, D.C., Jan. 24, 1947; M.D., Emory University School of Medicine, Atlanta, 1974; interned Grady Memorial Hospital, Atlanta, one year; ob-gyn residency, Navy Base, Portsmouth, VA, 1975-78; elected by South Mississippi Medical Society.

ETHRIDGE, CHRIS P., Jackson. Born Jackson, MS, Sept. 3, 1953; M.D., University of Mississippi

School of Medicine, Jackson, 1978; interned University Medical Center, Jackson, one year; orthopedic surgery residency, same, March 1979-December 1981; hand surgery residency, University Alabama, Birmingham, January 1982-June 1982; elected by Central Medical Society.

FINGAR, ANN RACHEL, Tremont. Born Chicago, IL, April 26, 1953; M.D., University of Illinois College of Medicine, Chicago, 1977; interned and family practice residency, University of Alabama, Huntsville, 1977-79; elected by Northeast Mississippi Medical Society.

FLEMMING, HENRY F., Gulfport. Born Greenwood, MS, Jan. 21, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned University Medical Center, Jackson, one year; medicine residency, same, 1980-82; elected by Coast Counties Medical Society.

GANDY, DAVID J., Jackson. Born Hattiesburg, MS, Oct. 25, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned University Medical Center, Jackson, one year; orthopedic surgery residency, Greenville Hospital System, Greenville, SC, July 1977-June 1981; pediatric orthopedics residency, Shriners Hospital, Greenville, SC, 1981-82; elected by Central Medical Society.

GEORGE, DAVID N., Jackson. Born Jackson, MS, April 17, 1953; M.D., University of Mississippi School of Medicine Jackson, 1978; interned and medicine residency, University Medical Center, Jackson, 1978-81; elected by Central Medical Society.

GRIFFIN, J. BROOKS, Jackson. Born St. Louis, MO, March 1, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and ob-gyn residency, University Medical Center, Jackson, 1978-82; elected by Central Medical Society.

GRAVES, MARILYN D., Jackson. Born Pontotoc, MS, Feb. 2, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned, University Medical Center, Jackson, one year; pediatric residency, University of Kentucky, Lexington, KY, 1971-72; pediatric residency, University Medical Center, Jackson, 1972-73; elected by Central Medical Society.

HAYLES, KENNETH J., Hattiesburg. Born Birmingham, AL, Feb. 3, 1949; M.D., Far Eastern University, Manila, Philippines, 1977; interned Ochsner Medical Foundation, New Orleans, one

year; ophthalmology residency, same, 1979-82; elected by South Mississippi Medical Society.

HIATT, WARREN A., JR., Biloxi. Born New Orleans, LA, Sept. 25, 1946; M.D., Vanderbilt University School of Medicine, Nashville, TN, 1971; interned Vanderbilt University Hospital, Nashville, one year; medicine residency, Johns Hopkins Hospital, Baltimore, MD, 1974-77; gastroenterology fellowship, Vanderbilt University Hospital, Nashville, 1977-79; elected by Coast Counties Medical Society.

HINES, KENNETH L., Greenwood. Born Memphis, TN, April 7, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned University of Louisville, Louisville, KY, one year; medicine residency, same, 1979-81; elected by Delta Medical Society.

HOLSTON, JAMES M., Laurel. Born Jones Co., MS, Aug. 1, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned University Medical Center, Jackson, one year; pediatrics residency, same, 1977-79; elected by South Mississippi Medical Society.

JOHNSON, NOEL H., Biloxi. Born Dothan, AL, July 3, 1952; M.D., University of South Alabama College of Medicine, Mobile, 1978; interned University of South Alabama Medical Center, Mobile, one year; ob-gyn residency same, 1979-82; elected by Coast Counties Medical Society.

KRAMER, MILTON, Jackson. Born Chicago, IL, Nov. 11, 1929; M.D., University of Illinois College of Medicine, Chicago, 1954; interned Cincinnati General Hospital, Cincinnati, OH, one year; psychiatry residency, same, 1955-57; child psychiatry residency, same, 1957-58; elected by Central Medical Society.

LEWIS, WILLIAM MARK, Forest. Born Clarksdale, MS, Feb. 27, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and family medicine residency, University Medical Center, Jackson, 1979-82; elected by Central Medical Society.

LOVITT, RODNEY N., Petal. Born Hattiesburg, MS, Feb. 10, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and family medicine residency, University Medical Center, Jackson, 1979-82; elected by South Mississippi Medical Society.

LOWERY, MICHAEL W., Hattiesburg. Born Laurel, MS, Aug. 13, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned Cin-

cinnati General Hospital, Cincinnati, OH, one year; neurosurgery residency, University Medical Center, Jackson, 1977-82; elected by South Mississippi Medical Society.

MAXEY, LOUIS T., Gulfport. Born Indianapolis, IN, Aug. 8, 1913; M.D., Lausanne University, Lausanne, Switzerland, 1953; interned Provident Hospital, Chicago, IL, one year; surgery residency, Cook County Hospital, Chicago, 1954-60; plastic surgery residency, Roswell Park Cancer Hospital, Buffalo, NY, one year; elected by Coast Counties Medical Society.

McGEE, GEORGE EDWARD, Hattiesburg. Born Hattiesburg, MS, Jan. 19, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned University of Louisville Hospital, KY, one year; surgery residency, same, 1978-82; elected by South Mississippi Medical Society.

PEDEN, RICHARD L., Long Beach. Born Starkville, MS, Feb. 8, 1948; D.O., Kansas City College of Osteopathic Medicine, Kansas City, MO, 1977; interned USPHS Hospital, New Orleans, one year; elected by Coast Counties Medical Society.

REEVES, DAVID L., Long Beach. Born Gulfport, MS, 27, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and pediatric residency, University Medical Center, Jackson, 1979-82; elected by Coast Counties Medical Society.

ROBERTS, DAVE A., Jackson. Born Parsons, KS, July 27, 1948; M.D., University of Missouri School of Medicine, Kansas City, 1973; interned Kansas City General Hospital, Kansas City, one year; neurology residency, University Medical Center, Jackson, MS, 1975-78; elected by Central Medical Society.

RUSSELL, RANDY H., Jackson, MS, April 23, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned Baptist Memorial Hospital, Memphis, TN, one year; ophthalmology residency, University Medical Center, Jackson, MS, 1979-82; elected by Central Medical Society.

SANDERS, C. J., Tupelo. Born Carrollton, MS, March 18, 1940; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and ob-gyn residency, University Medical Center, Jackson, 1976-80; elected by Northeast Mississippi Medical Society.

NEW MEMBERS / Continued

SATHYANARAYANA, VENKATESHIAH, Jackson. Born Mysore, India, July 1, 1947; M.D., The Bangalore Medical College, Bangalore, India, 1969; interned Bangalore Medical College Hospital, one year; pathology residency, University Medical Center, Jackson, MS, elected by Central Medical Society.

SCHIMMEL, JOHN C., Jackson. Born Vicksburg, MS, Jan. 8, 1947; M.D., Vanderbilt University School of Medicine, Nashville, TN, 1973; interned Stanford University Medical Center, Stanford, CA, one year; surgery residency, same 1974-75 and 1978-80; microsurgery fellowship, Davies Hospital, San Francisco, CA; elected by Central Medical Society.

WENDER, DAVID F., Jackson. Born, Springfield, MA, May 8, 1951; M.D., Dartmouth Medical School, Hanover, NH, 1975; interned Duke University Hospital, Durham, NC, one year; pediatric residency, same, 1976-78; neonatology residency, Yale University, New Haven, CT 1978-80; elected by Central Medical Society.

WHITE, CHESTER K., Tupelo. Born Fulton, MS, April 18, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and ob-gyn residency, University Medical Center, Jackson, 1978-82; elected by Northeast Mississippi Medical Society.

Medico-Legal Brief

(continued from page 26)

in Federal Court under the Federal Tort Claims Act alleging hospital negligence. The Court held against the hospital and in favor of the plaintiff. The Court said that the physician assistant performed adequately for his level of training, but held that the hospital's policy of having patients treated on their first visit by paramedically trained personnel without referring a licensed physician to review at least the patient's chart prior to discharge of the patient was a violation of an acceptable standard of care and that this violation was the proximate cause of her death. The Court awarded her husband \$245,178 for wrongful death and awarded the patient's estate \$74,360 for losses resulting from the patient's death. *535 F.Supp. 1261 (D.C., Pa., April 1, 1982)*

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Positions for part-time medical consultants are now available at the Disability Determination Services of Mississippi. The pay and hours are good. Interns and residents wanting to interrupt their training programs for a year or more are welcome to apply. If interested, call 922-6811, ext. 2277 (Dr. John Barr) or ext. 2000 (Mr. John Cook).

Situations Wanted

HEMATOLOGIST-ONCOLOGIST seeks associate or solo practice. Contact Thomas Twele, M.D., 272 Shadow Mountain, El Paso, TX 79912.

FAMILY PRACTICE resident seeks practice location in July 1983. Contact John D. Sites, M.D., 2002 Philip Dr., Muncie, IN 47302.

ANESTHESIOLOGIST seeks to relocate in state in solo, group or institutional practice. Contact M. T. Olivo, Jr., M.D., Box 794, Oxford, MS 38655.

SURGEON seeks location with established group in small city. Currently service as chief surgical resident at Ochsner Foundation Hospital. Available July 1983. Contact Thomas C. Kelly, M.D., 1516 Jefferson Highway, New Orleans, LA 70121.

PATHOLOGIST-ONCOLOGIST seeks practice location. Frank P. Urso, M.D., P. O. Box 1149, Akron, OH 44301.

CLASSIFIED

FOR SALE. Westinghouse X-ray machine, 100 MA with WSP—B-D tube. Contact E. E. Robinson, Jr., M.D., Lamar Building, Meridian, MS 39301; (601) 693-6644.

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IN CONCLUSION

Antibiotics are widely used in animal feed to prevent disease and promote growth, and the practice is creating antibiotic-resistant bacteria that can infect both animals and humans, a recent study concludes. The study involved 17 Massachusetts patients who became infected with a species of Salmonella resistant to a particular combination of antibiotics. The investigator identified it as the same bacteria which had infected cattle in 20 western and mid-western states. The frequency of human infection by antibiotic-resistant animal bacteria is unknown.

Cases of acquired immune deficiency syndrome (AIDS) continue to increase rapidly. The incidence of AIDS has roughly doubled every six months since the second half of 1979. According to the Centers for Disease Control in Atlanta, an average of one to two cases is diagnosed each day. Between June 1, 1981 and September 15, 1982, a total of 593 cases of AIDS were reported to the CDC. The overall mortality rate for those cases is 41% while the rate for cases diagnosed more than one year ago exceeds 60%.

In the first trial to assess the effects of different doses of genetically engineered interferon, researchers found evidence of tumor regression in a variety of cancers according to a National Cancer Institute study described in a recent issue of JAMA. A major part of the study - to assess the safety of the interferon - left researchers confident that it produces side effects no more difficult to handle than those which were reported for natural interferon. This trial and others have paved the way for more definitive tests now underway.

Medical records of employees who are exposed to toxic substances or hazardous physical agents should remain confidential and private, the AMA recently told the Occupational Safety and Health Administration. In commenting on a proposed regulation that would require employers to allow workers or their designated representatives look at records maintained by the company, the AMA supported the goal of the rule but recommended that it be amended to permit access only when the designated representative is a licensed physician.

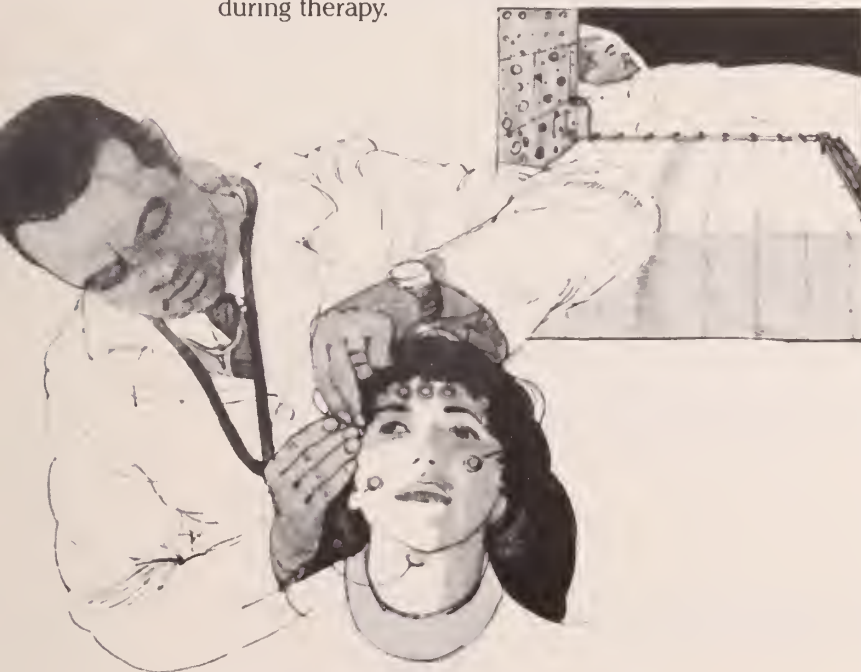
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- Caution patients about drinking alcohol, driving or operating hazardous machinery during therapy.



References: 1. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 4. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 5. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Kales JD: *Pharmacol Physicians* 4:1-6, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5:25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The

sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

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February 1983

JOURNAL of the **MISSISSIPPI** State Medical Association



This Month:
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Keeping Our Promise

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JOURNAL of the MISSISSIPPI State Medical Association



February 1983, Volume XXIV, Number 2

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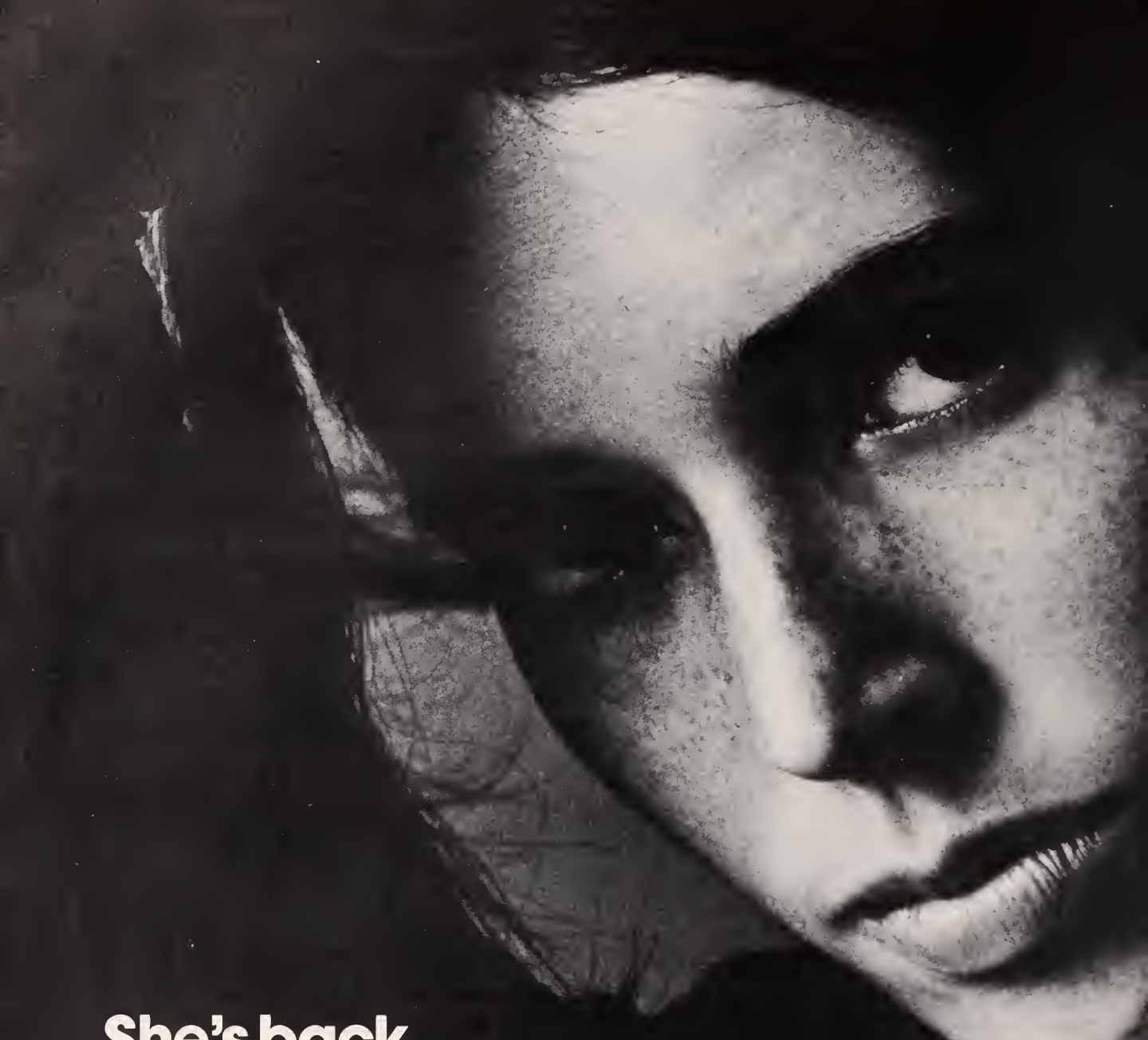
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She's back. How can you help her this time?

Many patients presented with physical symptoms are suffering from psychiatric illness, but are unaware of it. And while not all who suffer from mental illness or emotional problems need hospital treatment, hospitalization may be essential to provide a therapeutic environment in which the patient can effectively deal with his or her problems.

Riverside Hospital is a 56-bed, short-term care facility which provides intensive treatment of patients suffering from psychiatric illnesses, alcoholism, and drug dependencies. In Riverside's open, non-institutional environment, traditional and new, progressive psychotherapies are utilized.

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Riverside is licensed by the Mississippi Commission on Hospital Care, and is fully accredited by the Joint Commission on Accreditation of Hospitals.

The medical staff includes a large number of psychiatrists in private practice in the Jackson area. A toll-free number, 1-800-962-2180, has been established at the hospital for referral service to physicians on the active medical staff.

Physicians who have patients who would benefit from the type of treatment approach offered by Riverside may obtain referral information by contacting the Director of Admissions.

Riverside Hospital

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NEWSLETTER

February 1983

Dear Doctor:

The number of allied health professionals per office-based practice has increased almost five-fold in the past seven years, rising from 0.47 in 1975 to 2.25 in 1981, the AMA's Socioeconomic Monitoring System reported. The number of AHPs per physician also is growing. In 1975, there were 21 AHPs employed per 100 physicians. This number had increased 58% by 1981, when 49 AHPs were employed per 100 physicians.

The total number of full-time equivalent nonphysician personnel, which includes nurses and secretarial staff as well as AHPs, rose from 2.24 per practice in 1975 to 6.25 in 1981. Nursing staff increased from 0.67 to 1.50 per practice, and the secretarial staff rose from 1.10 to 2.50 per practice.

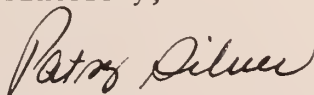
At least 70% of participating medical institutions can not comply with proposed new rules for collection of outstanding Health Profession Student Loans, said Sen. Orrin Hatch in a letter of protest to the Dept. of HHS. He said the rules would harm students, not institutions. A national meeting has been requested so that disputed portions of the rules can be discussed.

The AMA opposed a bill to authorize direct payment to non-MD "mental health specialists" under Medicare and Medicaid. In a statement to the House Subcommittee on Health, the AMA said the bill "would needlessly expand the Medicaid and Medicare programs while failing to assure the maintenance of adequate health care coverage for program beneficiaries."

The orphan drug act, which provides tax credits to stimulate the development of drugs for rare diseases, was signed into law. The act authorizes \$12 million over three years for start-up R&D funds for small companies, and it allows tax write-offs to cover 73% of drug development costs for larger pharmaceutical firms. The act is expected to benefit millions of Americans.

Health issues in the 80's will be discussed during MSMA's March 5-6 seminar in Jackson. A guest faculty will present such topics as "GMENAC Revisited: The Impending Doctor Glut," "Third Party Reimbursement: The Future Scene," and "Medical Care Today and Tomorrow." The program also includes discussions of current health legislation. Members and spouses are urged to attend.

Sincerely,



Patsy Silver
Managing Editor

In the treatment of your overweight patients...

Four ways to control the overactive appetite



COMMITMENT to lose weight



'MELFIAT® 105 once a day during the initial weeks of therapy



DIET tailored for each patient's needs



EXERCISE to improve physical fitness

When your overweight patients need an effective, short-term anorexiant, MELFIAT® 105 (phendimetrazine tartrate) is an excellent choice. According to a NIDA (National Institute on Drug Abuse) report, phendimetrazine appears to have less abuse potential than the amphetamines and certain other anorexiants.¹ And MELFIAT® 105 also offers your patients the convenience of once-a-day morning dosage.

Reference: 1. Sheu YS, Ferguson JA, Cooper JR: *Evaluation of the Abuse Liability of Diethylpropion, Phendimetrazine, and Phentermine*, unclassified document, ADAMHA, HHS. Office of Medical and Professional Affairs, NIDA, 1980, pp 10-15.

MELFIAT® 105 UNICELLES® 
(phendimetrazine tartrate) 105 mg

Short-term investment for long-term weight control



Reid-Provident Laboratories, Inc.
Atlanta, Georgia 30318

A Brief Summary
MELFIAT™ 105 UNICELLES® ©

(phendimetrazine tartrate) 105 mg Slow Release Capsules

INDICATIONS AND USAGE: Melfiat™ 105 (phendimetrazine tartrate) is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class (See CLINICAL PHARMACOLOGY) should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program.

Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.

Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.

Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.

Allergic: Urticaria.

Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.

Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phentolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdosage.

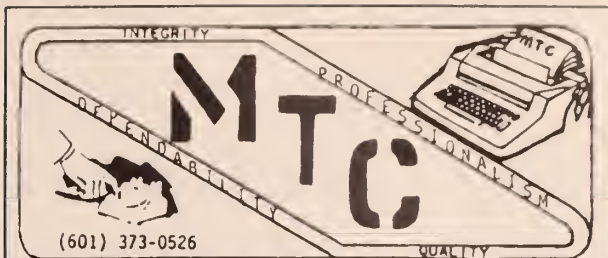
DOSAGE AND ADMINISTRATION: Since Melfiat® 105 (phendimetrazine tartrate) 105 mg is a slow release dosage form, limit to one slow release capsule in the morning. Melfiat® 105 (phendimetrazine tartrate) is not recommended for use in children under 12 years of age.

HOW SUPPLIED: Each orange and clear slow release capsule contains 105 mg phendimetrazine tartrate in bottles of 100. NDC 0063-1082-06.

CAUTION: Federal law prohibits dispensing without prescription.



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Atlanta, Georgia 30318



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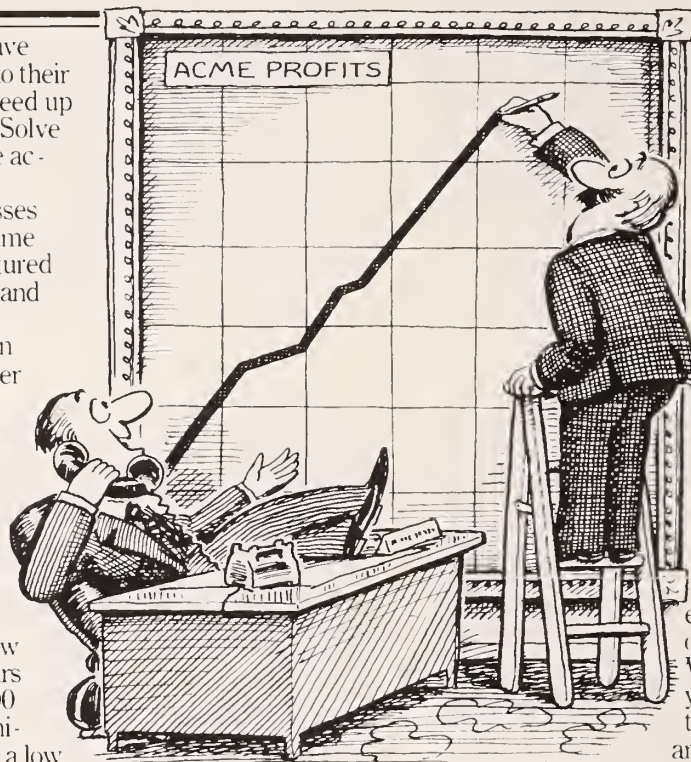
There's no prepayment for usage, either. So you pay for the services you use after you've used them. That can definitely help your cash flow.

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DATELINE

CommuniCare Now In
Central Counties

Jackson, MS - CommuniCare, MSMA's patient inquiry program, has been expanded to include the six counties in the Central Medical Society area. Already available to patients in Warren, Sharkey and Issaquena counties, CommuniCare emphasizes the importance of good communications in the patient-physician relationship, urges patients to talk directly with their physician when they have questions, and provides an additional resource for inquiries.

Awards For Refusing
Cigaret Ad \$\$\$\$\$

New York, NY - More than 30 magazines that refuse to accept cigaret advertising were honored by the American Lung Association in its first annual media awards. Cigaret manufacturers spent more than \$309.1 million on magazine advertising in 1981, up from \$268.3 spent in 1980. When combined with tobacco and smoking accessories, cigarettes topped the list of advertisers in expenditures for 1981, surpassing automobiles, liquor, sports equipment, and apparel.

NHSC Private
Practice Option

Chicago, IL - The AMA is participating in the Private Practice Option, a program to attract physicians to areas of need. The option, now offered to National Health Service Corps physicians, permits them to establish a private practice in a manpower shortage area. Last year more than 400 physicians took the option. The AMA is attempting to identify private practice opportunities in areas of need for consideration by NHSC physicians.

Divide HHS
For Efficiency

Chicago, IL - The Dept. of HHS, the government's biggest agency, should be divided into a department of health and a separate department of human services, to make it more manageable and effective. The AMA made that recommendation, commenting on the resignation of Sec. Schweiker and the nomination of former Rep. Margaret Heckler to replace him. The statement also expressed disappointment that the counsel of major health associations was not sought in making the appointment.

AMA Views DRG
With Caution

Chicago, IL - AMA will urge Congress and the secretary of HHS "to take an extremely cautious approach" to the diagnostic related groups (DRG) method of prospective hospital reimbursement. At its December meeting the AMA House of Delegates called on HHS to broaden its experimental reimbursement formula beyond the DRG concept, to implement the DRG concept on an experimental basis only, and to restrict implementation to selected areas before going nationwide with it.

Pinworms work the night shift



Artist's interpretation:

The nocturnal egg-laying of the female pinworm causes acute perianal itch...making children shift sleeplessly through the night.





When mild
to moderate pain
is a side effect
of "Fitness"

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(ibuprofen)

measures up...
at a reasonable
cost!

**A Single-Entity Pain Reliever
As-Good-As or Better-Than Codeine
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"...particularly effective in soft tissue disorders including sports injuries,"¹ Rufen stops pain at the site of injury and inflammation, not at the level of central perception. There is no dulled sensorium, no special need for warnings about driving or cautions about use of machinery. Your patient gets fast, effective pain relief...potent anti-inflammatory action...excellent tolerance...*plus* the exceptional economy that only Rufen offers. Next time one of your patients asks for pain relief, let Rufen show you how it measures up.



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See next page for brief summary of prescribing information.

Measure RUFEN® (ibuprofen) against "standard" mild to moderate pain

Dental pain and episiotomy pain are predictable, reproducible "standards" that make possible objective comparisons of effectiveness of different analgesic agents.

- Measured against 15, 30 and 60 mg doses of codeine phosphate in a double-blind study of 287 patients, 400-mg doses of ibuprofen proved "significantly better than codeine on almost all pain intensity, degree of relief and duration of analgesia parameters."²
- Measured against a propoxyphene-acetaminophen combination for pain relief after 3rd molar extractions, ibuprofen proved equally effective and caused fewer side effects. Ibuprofen was associated with faster recovery, evidenced by more rapid reduction of trismus and return to normal function.³
- Measured against post-episiotomy pain in 30 patients, "ibuprofen was effective in treating the swelling as well as pain...during the first and worst days. Therefore, it is not only the analgesic but also the anti-inflammatory effect of ibuprofen that are the beneficial factors..."⁴



Measure RUFEN® (ibuprofen) against any mild to moderate pain

RUFEN	Acetaminophen + codeine combinations
• single-entity, peripheral-acting analgesia	• combined drugs act partly through central opioid pathways
• powerful treatment of both pain and inflammation	• virtually no treatment of the inflammatory component
• better tolerated than aspirin	• combined side effects of two drugs—warning required about driving or operating machinery; possible respiratory depression with alcohol, tranquilizers, other common medications
• no narcotic risk, red tape, records	• narcotic precautions required
• matchless economy in a modern NSAID	

References:

1. Hart FD, Huskisson EC, Ansell BM in Hart FD (editor): Drug Treatment of the Rheumatic Diseases, 2nd Ed, Adis Press, Balgowlah, Australia, 1982, p. 30.
2. Rondeau PL, Yeung E, Nelson P: Canad Dent Assoc J 46:433-439, 1980.
3. Selwyn P and Giles AD: Br Jrl of Clin Practice, Supplement 6, Safe and effective analgesia following dental surgery: A comparison of brufen and distalgesc. Pg 87-90, 1980.
4. Taina E: Curr Med Res Opinion, 7:423-428, 1981.



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And Rufen® Measures Up Best

RUFEN® (ibuprofen) Tablets

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain. Treatment of primary dysmenorrhea.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angio-edema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally, however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin: Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS: Incidence greater than 1%. **Gastrointestinal:** The most frequent adverse reaction is gastrointestinal (4 to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS). *Incidence 3% to 9%.

Incidence less than 1 in 100. Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome and alopecia. **Special Senses:** hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) (see PRECAUTIONS). **Hematologic:** neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura eosinophilia, decreases in hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Allergic:** syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasms (see CONTRAINDICATIONS). **Renal:** acute renal failure in patients with preexisting significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. **Miscellaneous:** dry eyes and mouth, gingival ulcers, rhinitis.

Causal relationship unknown. Gastrointestinal: pancreatitis. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri. **Dermatologic:** toxic epidermal necrolysis, photo-allergic skin reactions. **Special Senses:** conjunctivitis, diplopia, optic neuritis. **Hematologic:** bleeding episodes. **Allergic:** serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (sinus tachycardia, bradycardia, and palpitations). **Renal:** renal papillary necrosis.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Dysmenorrhea: 400 mg every 4 hours as necessary

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for the relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

Put pinworms out of work...

Promptly paralyzes pinworms and roundworms

Antiminth® (pyrantel pamoate) has a unique, rapid immobilizing effect on worms. Unlike mebendazole, which blocks glucose uptake—slowly “starving” helminths to death—Antiminth quickly acts on the neuromuscular junction to promptly paralyze parasites.

97% efficacy with a single dose

A single dose of Antiminth delivers rapid clinical and parasitological cures, “Single doses... showed high overall efficacy against *Enterobius vermicularis* (97.2%) and *Ascaris lumbricoides* (97.5%).”¹

Simple, well tolerated therapy

Antiminth offers ease of administration and patient tolerance. “...when compared to the other single dose agents available, [Antiminth] has the advantage of being non-staining and may be better tolerated.”²

The dosage form children like

Antiminth is available as a pleasant tasting, caramel-flavored oral suspension. Effective in just



one dose against pinworm and roundworm—in both children and adults—Antiminth is easy-to-administer and easy-to-take.

Respected around-the-world

In some parts of the world, large populations are afflicted with helminthic infections. Physicians in endemic areas have become experts on parasitic diseases—and have come to rely on Antiminth for the rapid cure of infestations. Antiminth is recommended as an agent of first choice for pinworm and roundworm by leading medical authorities.³

Warnings

Usage in Pregnancy Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions

Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions

The most frequently encountered adverse reactions are related to the gastrointestinal system. Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration

Children and Adults Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

References 1. Pitts NE, Migliardi JR: *Clinical Pediatrics* 13:87, 1974. 2. Modell W: *Drugs of Choice* 1980-1981. C. V. Mosby Co., St. Louis, 1980, p. 362. 3. Goodman LS, Gilman A: *The Pharmacologic Basis of Therapeutics*, 6th edition, MacMillan Publishing Co., Inc., New York, 1980, p. 1032.



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Pfizer Inc. New York, N.Y. 10017

Prescribe Antiminth® Suspension
(pyrantel pamoate) 50 mg pyrantel base/ml

Cures pinworm and roundworm fast...with a single dose

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ORIGINAL PAPERS

Improving the Continent Ileostomy

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THE CONTINENT ILEOSTOMY represents a major advance toward improving the quality of life for the ileostomy patient. It consists of a valve and a pouch, both of which are fashioned from the lower small bowel. Following coloproctectomy, this anatomical arrangement provides restoration of the capacity for storage of bowel content and control of its discharge. The pouch is emptied two to three times per day by insertion of a catheter. There is no need to wear a bag.

The details of our early experience with the continent ileostomy were the subject of a prior report.¹ At that time, nine continent ileostomies had been constructed. The series now includes nineteen patients and much has been learned in regard to improving overall results.

Kock's Antiperistaltic Valve

The concept of a continent ileostomy was originated by Kock in 1969.² His initial experiences were concerned with utilization of the rectus abdominus muscle to serve as a constricting force about the efferent loop of bowel and thus provide continence. This approach proved to be ineffective and his next effort involved intussusception of a loop of bowel into the pouch to form a valve. This represented retrograde intussusception in an antiperistaltic direction (see Figure 1). Many surgeons have adopted this technique over the years including Beahrs³ and Golliger.⁴ All have expressed major concern in regard to the incidence of valve slippage which has exceeded 20% in many experiences. In his report

ANTIPERISTALTIC VALVE

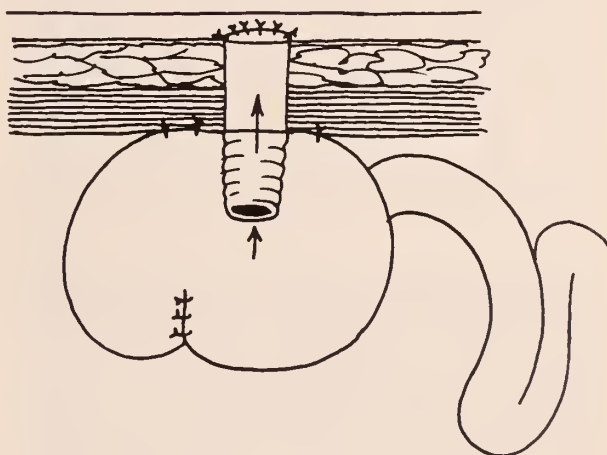


Figure 1. Peristalsis favors dissuspension of the Kock valve.

from the 1981 session of the American College of Surgeons, Hoexter states that "despite improvements, nipple reduction requiring several operative corrections is still a major drawback."⁵ Valve slippage represents dissuspension and is manifest by leakage of intestinal content along with difficulty in passing a catheter into the pouch (see Figure 2). Among our first five cases, two developed slippage of their anti-peristaltic valves and required reoperation. This experience motivated us to explore other possibilities in regard to improving valve stability.

Dr. Barnett is engaged in the private practice of surgery in Jackson, MS.

SLIPPED VALVE WITH INCONTINENCE

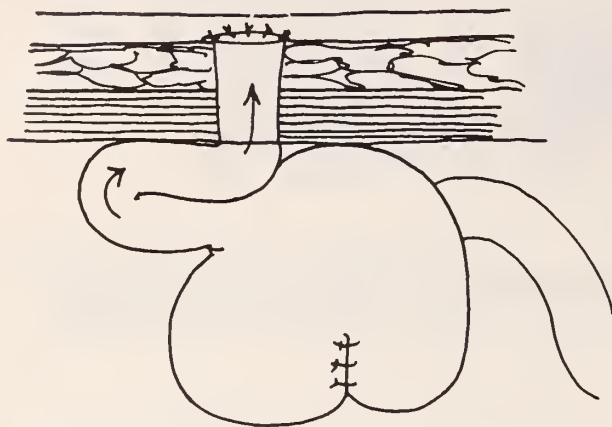


Figure 2. Extruded antiperistaltic valve which leaks.

ISOPERISTALTIC VALVE WITH MARLEX COLLAR

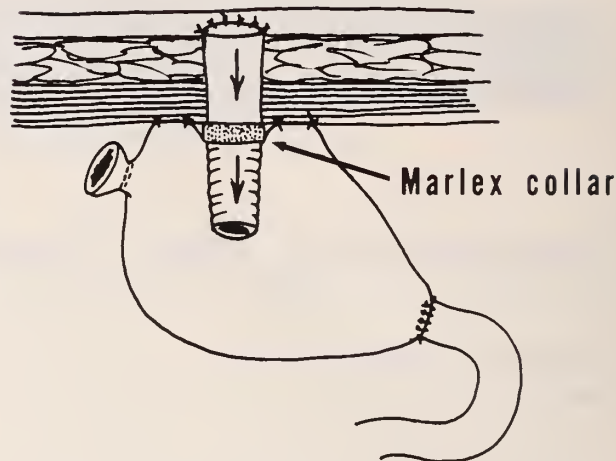


Figure 3. The isoperistaltic valve directs peristalsis toward the pouch and this minimizes the tendency for valve extrusion.

The isoperistaltic valve

Achievement of valve stability amounts to the maintenance of a segment of bowel in a position of intussusception. Naturally occurring intussusception always develops in a forward, isoperistaltic direction. Indeed, operative intervention is not infrequently required for its reduction. These facts were operative in encouraging us to explore the feasibility of utilizing an isoperistaltic valve for the continent ileostomy. The transected ileum is closed, following which the terminal 30 cms of ileum are sewed together as two 15 cm limbs. This bowel is opened along its antimesenteric border and folded to form a pouch as previously described. The afferent ileum is then divided 15 cms above its entrance into the pouch and is intussuscepted forward to form the valve which should project for 5 cms into the pouch. The intussusceptum is stapled to the intussuscipten. A marlex collar is placed about the neck of the valve. The remaining 5 cms of bowel is used to traverse the abdominal wall and form the stoma. The proximal, transected ileum is then anastomosed to the side of the pouch (see Figure 3).

Sixteen consecutive isoperistaltic valves have been constructed over a period of three years and none have necessitated reoperation for valve slip-page.

The Pouch

A pouch is necessary in order to provide storage capacity after the colon has been removed. Several long suture lines are employed during construction

and leakage from this area has served as a source of considerable concern. Unquestionably, surgical expertise in bowel anastomosis along with the observance of all basic principles for intestinal surgery represent mandatory requisite for success. The employment of stapling devices in some instances is appropriate in order to save time. Closure of the pouch in the area of the valve poses a particular challenge because of problems with excessive tension. Many reported failures have resulted from suture line dehiscence in this area. The older patient who has sustained colectomy for familial polyposis may present the unique findings of mesenteric panniculitis. This condition is characterized by tremendous thickening of the mesentery along with multiple, enlarged, hard lymph nodes. The rigid, unyielding mesentery serves as a formidable obstacle in regard to folding the intestinal plate during pouch construction. The resulting tension provides suture line stress to such an extent that leakage may result. It has been our practice to employ reinforcement of such stressed suture lines by sewing the antimesenteric surface of proximal normal bowel over the area in question. Another potential source of pouch leakage arises when it is sutured to the abdominal wall in preparation for creation of the stoma. Of necessity these sutures must be placed through that portion of the pouch which lies in close proximity to the valve. The thin bowel in this area is

under considerable tension and may be easily torn. Upon completion, the entire pouch must be inspected for areas of discoloration which may signify impaired circulation. It is mandatory that the pouch be distended with saline in order to locate significant leaks. Many ulcerative colitis patients come to surgery under the influence of steroid therapy which has been in effect for prolonged periods. The question of possible adverse effects of steroid therapy upon pouch healing has been a source of concern. Our experience suggests that a successful continent ileostomy can be constructed in patients receiving steroid therapy without incurring additional significant risk. Eleven of our coloproctectomy patients were operated upon during heavy steroid therapy and one experienced pouch leakage.

Attempts at construction of a continent ileostomy should be avoided if peritonitis is encountered during coloproctectomy. Such a patient may be converted from a conventional to a continent ileostomy at a later date. One of our patients was successfully converted two years after coloproctectomy for toxic megacolon with perforation. It is also inadvisable to provide a continent ileostomy in those cases of malignant degeneration with peritoneal metastasis complicating ulcerative colitis. We have not hesitated to construct a continent ileostomy in those cases of malignant change, where the carcinoma remains grossly confined to the colon. We are persuaded that it is better to construct the continent ileostomy at the time of coloproctectomy in the usual case rather than electively accepting a second stage operation for conversion. The bowel is more pliable, less edematous and affords a thinner wall, all of which allow a better technical result.

Postoperative Management

Catheter gastrostomy is always used for postoperative bowel decompression following creation of a continent ileostomy. Elimination of nasogastric suction significantly decreases postoperative discomfort. No complications of the procedure have been encountered.

Routine postoperative pouch decompression is provided by the placement of an indwelling #28 foley catheter at the time of surgery. It is connected to a source for continuous, low level suction. Postoperative return to bowel activity is accompanied by a progressive decline in output from the catheter gastrostomy while the flow from the pouch catheter reflects an increasing volume.

Much importance has been assigned to postoperative pouch decompression by surgeons who continue to use the antiperistaltic valve. They feel that the



Figure 4. Continent ileostomy stoma is located near the pubic hair line while the healed site of the previously existing conventional ileostomy can be seen above.

maintenance of a low level of pressure within the pouch decreases the likelihood of valve slippage. Three to four weeks of postoperative pouch decompression has been recommended. With the increased stability of the isoperistaltic valve we have been able to lower the time for postoperative pouch decompression to seven days.

Conversion of Conventional Ileostomy

We have successfully converted seven patients from Brooke type ileostomies to the conventional variety. No group is more appreciative than those individuals who desire and undergo successful conversion after living for a period with a conventional ileostomy.

It has been our practice to move the site of the stoma to a lower level upon the abdominal wall during conversion. The optimal site appears to be just above the pubic hair line (see Figure 4). This is feasible because the stoma can be placed in close proximity to the bony prominence of the pubis, a position which is incompatible with the successful fitting of a bag.

There is a prevailing opinion among surgeons that conversion from the conventional ileostomy is attended by a lower success rate than that obtained by construction of the valve and pouch at the time of colectectomy. Shrock reported a failure rate of 13% with primary construction at the time of colectectomy, while the figure was 46% among those converted from a conventional ileostomy.⁷ Gelerent also obtained a better success rate among those patients who received a continent ileostomy at the time of colectectomy.⁸ Factors which have been considered to play a role in the final result obtained after conversion include age, sex, obesity, condition which necessitated colectectomy and conventional ileostomy malfunction. In younger patients the intestinal wall is usually thinner, less rigid and easier to manipulate. Most every series of reported cases relates a higher incidence of valve slippage in males than in females. This may result from the stronger abdominal musculature in the male with resulting increased pressure upon the pouch, which could tend to produce extrusion of the valve. Following colectectomy for ulcerative colitis, patients usually gain considerable weight. This tendency toward obesity is accompanied by excessive deposits of fat in the mesentery of the ileum. During the intussusception maneuver for creation of the valve, the mesentery serves as a considerable restraining force. Excessive fat deposits produce a thickened mesentery, and this contributed additionally to valve instability with increased likelihood of slippage. The nature of the condition which served as an indication for prior colectectomy is important because those individuals who had familial polyposis may evidence mesenteric panniculitis, as mentioned above. These changes in the mesentery, depending upon their extent, have posed difficulties during valve construction among some patients in our series. Where colectectomy was required because of ulcerative colitis, anatomical conditions are usually much more favorable for successful continent ileostomy construction. In some individuals, surgical revision of an existing conventional ileostomy is necessary because of the development of complications. The option of conversion to a continent ileostomy must be considered under these circumstances. When stenosis has existed for a period of time, the bowel wall becomes dilated and edematous. These changes along with hypertrophy of the muscle may produce considerable intestinal

rigidity. The resulting loss of pliability requires more forceful efforts toward achieving intussusception of the bowel, and this resistance increases the likelihood of valve slippage. The stable characteristics of the isoperistaltic valve are especially attractive under these circumstances.

Summary

Improvements in surgical construction and management of the continent ileostomy have been impressive over the last several years. The major early drawback was valve slippage which produced leakage, difficulty with intubation and frequently necessitated reoperation. The development of the isoperistaltic valve has effectively controlled this problem. Sixteen consecutive isoperistaltic valves have been fashioned and none have necessitated reoperation for slippage. Strict adherence to established basic principles for intestinal surgery must be maintained if pouch leakage is to be prevented. Stapling devices are valuable in closing the long suture lines. Steroid administration before and after continent ileostomy surgery has not adversely affected pouch healing in our experience. The period of post-operative pouch decompression with an indwelling catheter has been decreased by two to three weeks since adoption of the isoperistaltic technique for valve construction. Seven patients have been successfully converted from conventional to continent ileostomies. While construction of the continent ileostomy at the time of colectectomy is still the best plan, nevertheless, an existing conventional ileostomy can be converted with excellent chances for success, if the isoperistaltic valve is used. ★★

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Hydrocephalus and Shunt Malfunction

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HYDROCEPHALUS (hydro — water, cephalus — head), is the term used to describe enlargement of the ventricular system of the brain. This accumulation of cerebrospinal fluid (CSF) occurs when there is an imbalance of CSF formation and its absorption.

A major fraction of CSF is formed within the cerebral ventricles at a rate of approximately 500 ccs per day.¹ This CSF production is a very steady state and the formation of hydrocephalus is basically secondary to an obstruction of CSF pathways.

Normally, CSF is absorbed by the arachnoid villi which are located within the sagittal sinus. If the CSF exits from the ventricular system but fails to be absorbed at the level of the arachnoid villi, this is termed communicating hydrocephalus. If there is a blockage of the ventricular CSF pathways, such as aqueductal stenosis, then it is noncommunicating hydrocephalus.

Infantile hydrocephalus is a congenital disorder that occurs approximately three to four per thousand births. Congenital examples outnumber the acquired types 3 to 1.³ With first pregnancy or with increasing age of the mother, the incidence of central nervous system malformations of all types is increased.

Independent of the etiology of the hydrocephalus, the best treatment at the present time is a shunt mechanism which diverts CSF from the ventricular system to another body cavity where the spinal fluid can be absorbed. At the present time there are two shunts that are commonly utilized.

The ventriculo-peritoneal shunt is one in which the spinal fluid is diverted into the free peritoneal cavity (see Figure 1A). The V-P shunt has the advantages of a low infection rate, a simple surgical procedure and that growth of the child can be anticipated by inserting extra length of tubing.

The second shunt system that is quite popular was introduced by Nulsen and Spitz in 1952 and consists of diverting CSF from the lateral ventricle to the

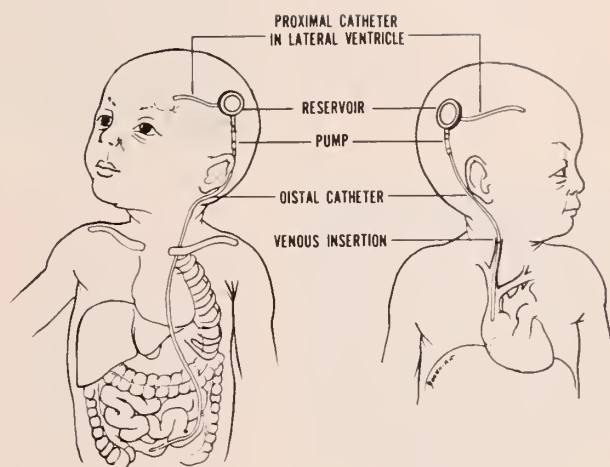


Figure 1A. Left side of illustration depicts a ventriculo-peritoneal shunt.

Figure 1B. Right side illustrates a ventriculo-atrial shunt with the venous catheter entering the right jugular vein and tip placement within the right atrium. The components of the shunt system are reservoir, pumping mechanism with pressure device and distal catheter.

right atrium of the heart (ventriculo-atrial shunt).⁴ The shunt tubing is inserted into the right atrium via the internal jugular vein (see Figure 1B). This shunt system is very reliable but it has two frequent problems. There is an increased risk of bacterial colonization of the shunt during bouts of septicemia. This is especially true of children with frequent bacterial infection that myelomeningocele patients develop. The second problem is that as the child grows, the tube progressively pulls out of the heart. When it reaches the superior vena cava and a region of less turbulent flow it occludes.

The components of most shunt systems are as follows. There is a ventricular catheter that is inserted via a burr hole through the cortical mantle into the lateral ventricle. It is connected to a reservoir which may be tapped to measure pressure, sample CSF or instill antibiotics. The reservoir is connected

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to a valve system which may be located proximally as illustrated, or distally, which regulates the CSF pressure. The final component of the shunt system is the distal catheter which delivers the cerebrospinal fluid for absorption. The distal catheter is placed in the peritoneal cavity in the case of V-P shunts and placed into the right atrium in the case of the V-A shunt (see Figure 1).

The most common shunt-related problem encountered in the hydrocephalic child is shunt malfunction secondary to blockage of flow of CSF. The occlusion may occur within the shunt system proximally in the ventricular tubing or distally in the heart (V-A) or abdomen (V-P). Occlusions within the shunt are usually secondary to a fibrin debris that blocks the flow of CSF. This may occur shortly after shunt insertion or years later. Another reason for failure is blockage because the omentum may wrap around the peritoneal tubing.

Normally the shunt maintains the cerebrospinal fluid pressure between 40 and 100 mm of water. As the shunt becomes progressively occluded the CSF pressure rises producing increased intracranial pressure. This may occur rapidly with sudden shunt malfunction or quite slowly with a gradual increase in intracranial pressure.

Symptoms and Signs of Shunt Malfunction

There is usually no problem in recognizing the clinical syndrome of shunt obstruction in patients with sudden total shunt blockage. The child becomes quite lethargic, may have vomiting, headache, and rapidly becomes comatose. If the pressure is not relieved promptly, the child will then have brainstem herniation with decerebrate rigidity and respiratory arrest. This constellation of signs and symptoms usually occur within 12 to 48 hours. On occasion the progression occurs in a very brief period of time.

However, in most patients, the shunt becomes obstructed by a gradual process if epithelialization of the fibrin clot occurs. The CSF pressure gradually rises over a period of days to weeks. It is often quite difficult early on to be sure the child's symptoms are secondary to shunt occlusion. Each child, however, has his own fairly definite symptom complex which will be repeated on repeat episodes of shunt malfunction. Parents become very attuned to this problem and may recognize the symptoms of shunt occlusion quite early, often before the physician can detect any physical signs. We have made it a general rule that if the parents feel that the shunt is malfunctioning, the burden of proof is on the physician to prove otherwise.

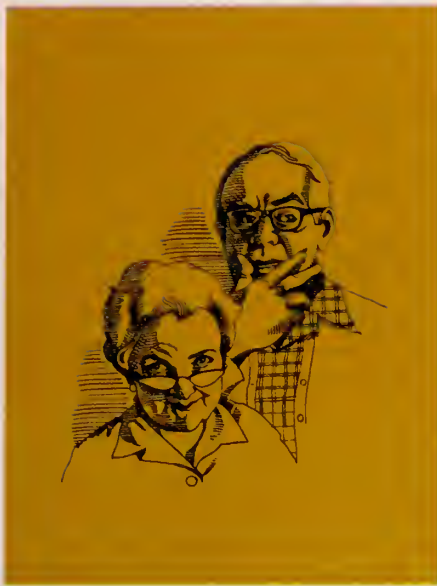


Figure 2. This figure depicts a computed axial tomographic section at the level of the lateral ventricles. The ventricles are dilated and the tubing is noted to be imbedded in cerebral tissue.

In cases of gradual shunt malfunction, the presenting symptoms may be headache or irritability. The child often becomes inattentive at school with minor behavioral alterations. On occasion, the changes are very subtle and will be manifest by impaired school performance and change in personality. Rarely the presenting problem will be exacerbation of a previous seizure problem.

As the pressure gradually rises, however, the child will then begin to show the more common signs of increased intracranial pressure with lethargy and slowed mentation. The child will be noted to be quite irritable upon awakening and early morning vomiting may ensue. It is rare, however, for other signs of GI disturbance, such as diarrhea. Often the child will appear pale and quite ill. Fever is not a sign of shunt malfunction. Even in the rare case of shunt infection and occlusion, fever is rarely present.

Therefore, in the irritable child with high fever and vomiting rarely is the shunt the etiology of



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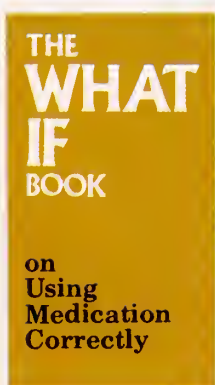
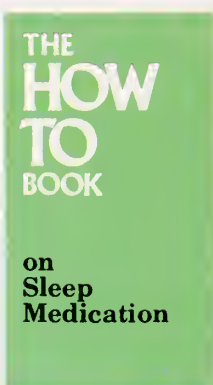
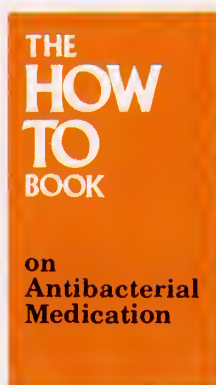
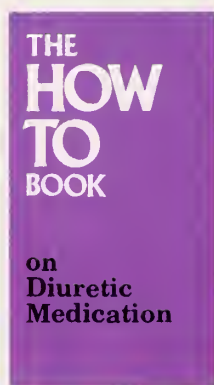
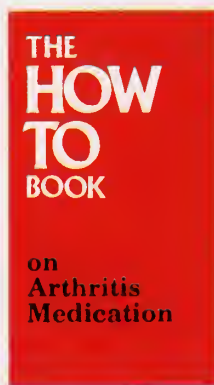
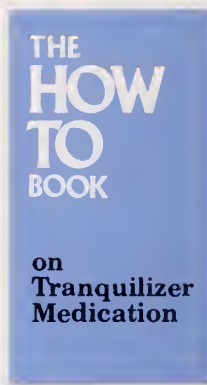
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infection. However, in the occasional patient with high fever, leucocytosis in which no source of infection is available, the only solution is to tap the shunt. This does run the increased risk of infecting the shunt during the septicemia and should be the last resort.

Shunt Evaluation

If the history strongly suggests shunt malfunction as the etiology of the child's problem the child should be referred for assessment of shunt function by a neurosurgeon. If the presenting symptoms are indefinite the primary physician may utilize a portion or all of the shunt evaluation to be described.

The following discussion will be a step-wise assessment of shunt function that we utilize on our Pediatric Neurosurgical Service.

The first step in the evaluation is to pump the shunt mechanism. If the shunting mechanism does not compress it is good evidence that the shunt is malfunctioning. However, if the shunt pumps this does not mean that the shunt is working. The pressure normally should be 40 to 100 mm of water within the intraventricular system. If the shunt has slowly developed a fibrin accumulation within it, the CSF pressure may have gradually risen to 150 to 200 mm of water, producing a very ill child. It is impossible to detect this small difference in pressure (200 mm H₂O vs 50 mm H₂O) by palpation of a shunt mechanism. Also some shunts will pump readily but not advance CSF along the system. In this case the shunt by palpation will appear to be working but in reality be nonfunctional.

When a shunt is noted to compress but refills slowly it is because there is a limited amount of CSF available at the proximal ventricular shunt tip. This means that either the ventricles are small or there is proximal occlusion of the shunt tip. CAT scan (computed axial tomography) will resolve this difference quite readily (see Figure 2). In the case illustrated, since the shunt refilled slowly and yet the ventricular system is dilated, the shunt is obviously not working.

The second step is palpation of the shunt tubing itself to see if there is an interruption of the tubing. If the shunt tubing has become disconnected there may be a small separation of the tubing. This allows the passage of some spinal fluid down the fiber sheath between the separated tubing but results in an increased intracranial pressure (see Figure 3). If the shunt tubing seems to be intact by palpation then the third step is to x-ray the child to verify that it is indeed connected. It is sometimes quite difficult in the older child to palpate the shunt or differentiate



Figure 3. The upper arrow indicates a pathological separation of the shunt tubing. This small separation is secondary to fracture of the shunt tubing. This child had gradual onset of increased intracranial pressure. The lower arrow is pointing to distal tubing. The wide separation of tubing between the first and second arrows represent a radiolucent reservoir system. This system is not visualized by radiographic examination and therefore is a normal finding.

the fibrous tract from the shunt tubing itself. X-rays also may be quite misleading as many of the shunts currently available have a radiolucent area that is not visible on x-ray. This will give the appearance of gaps between the shunt tubing when there are actually none (see Figure 3). Previous x-rays during a period of time when the shunt is functioning are very useful to the physician for comparison purposes. They are part of our standard evaluation.

The fourth step is a computerized axial tomography (CAT) scan. The CAT scan is quite useful if there are previous CAT scans for comparison. Upon shunt malfunction the lateral ventricles will enlarge with detectable changes by CAT scan. Since hydrocephalic children with no increased pressure, i.e. functioning shunts, may have normal, small or large ventricles the demonstration of an enlarged ventricular system does not mean shunt malfunction. Previous scans for comparison purposes are extremely useful. Routine CAT scans are part of our regular periodic evaluation of hydrocephalic children.

The final diagnostic evaluation in symptomatic children is to tap the shunt and measure the CSF pressure. This is only useful if the shunt system is pumping and refilling adequately. Measuring the pressure is a definitive test for shunt function. If the CSF pressure is greater than 100 mm of water it verifies that the shunt is indeed not functioning.

Normal pressures of 60 mm or less are indicative of adequate function unless the shunt was pumped frequently prior to the CSF sampling.

Puncture of a shunt should be performed by the neurosurgeon who is to make the final decision as to shunt revision. There is a definite increase in infection rates associated with tapping shunts secondary to contamination by the introduction of bacteria from the skin during the shunt puncture. However, in emergency situations in which children appear in the emergency room with evidence of severe increased intracranial pressure, herniation and pending respiratory arrest, the shunt should be tapped by the physician on duty. We recommend utilizing a 25 gauge butterfly. After shaving and thoroughly cleansing the area, the needle is introduced into the reservoir system. The CSF should come quite freely. It is then possible to measure the height of the column of CSF within the reservoir and readily determine the adequacy of the shunt. In the emergency situation the CSF will be under high pressure and should be slowly released. The child will immediately improve if the pressure has been up for only a brief period of time.

Further evaluation of the shunt may be obtained by injecting contrast material (Conray 60) and following its clearance from the system per x-ray examination. Normal clearance times have been established for various types of shunts. We do not feel that this procedure adds enough information to merit the time, radiation, or expense.

In review, the steps to determine shunt function are as follows:

- 1) pump the shunt
- 2) palpate the shunt tubing
- 3) x-ray the shunt system
- 4) CAT scan
- 5) tap shunt (This should be performed early in a life threatening situation).

As soon as the physician suspects shunt malfunction to be the most likely diagnosis the child should be referred for emergency neurosurgery evaluation.

Summary

Hydrocephalus is a common childhood disorder (3-4/1,000 births); at the present time the best available treatment is a CSF shunt system.³ Primary physicians who follow children with shunts should obtain baseline evaluations while the shunt is functioning properly. This should include neurological evaluation with special attention to intellectual function and personality. X-rays of the shunt system are necessary for comparison purposes and CAT scans are useful. A neurosurgeon familiar with the child should be readily available.

The clinician needs to keep a high index of suspicion for shunt problems in these children. Changes in behavior patterns or intellectual function should alert the physician to the possibility of shunt malfunction. Most of all, if the parents are convinced that the shunt is not working, the physician should consider the shunt non-functional until proven otherwise.

Conclusion

We have outlined the common presenting signs and symptoms of shunt malfunction. A simple systematic examination has been outlined to determine shunt patency.

Because of the frequency of shunt malfunction, and the seriousness of delay of the treatment, prompt diagnosis is critical in this group of patients. ★★

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Bone Marrow Necrosis Secondary to Hyperparathyroidism

MEHDI TAVASSOLI, M.D.

Jackson, Mississippi

BONE MARROW NECROSIS is an uncommonly recognized lesion of diverse etiology. The diagnosis is usually made at postmortem examination, therefore, most reported cases are found in pathologic literature. The diagnosis can rarely be made on smears of bone marrow aspirate. In recent years, the advent of Jamshidi needle which permits routine biopsy of adequate marrow tissue has led to recognition of this lesion more commonly than reported hitherto.¹

Marrow necrosis has been reported in the course of septicemia, carcinomas with bone metastasis, ionizing radiation, acute leukemia and sickle cell anemia.² Its pathogenesis is not well understood, but it has generally been attributed to acute obstruction of the marrow's microcirculation. We report a case of hyperparathyroidism in whom marrow necrosis occurred with elevation of serum calcium. We believe the lesion was caused by the precipitation of calcium salts in the microcirculation of the marrow.

Case Report

A 62-year-old obese female was seen for increasing pain over the medial aspect of the knee for several months. Two years before, she had been found to have a serum calcium of 13.5 mg%, but records of her serum phosphorus levels are not available. X-rays of the hands, skull, chest and upper gastrointestinal tract had all been normal, and she was treated with 2 gms of phosphorous per day. In addition, she had been receiving hydrochlorothiazide and alpha-methyldopa for essential hypertension. Before her admission, she had been noted to have become progressively more demented and agitated with episodes of confusion.

Physical examination demonstrated moderate dementia and confusion. The spleen was palpated 4 cm below the left costal margin. There were tender, subcutaneous nodules over the lateral aspect of the right thigh.

From the Veterans Administration Hospital and University Medical Center, Jackson, MS.

Significant laboratory findings included a hemoglobin of 8.1 g/dl and a platelet count of 185,000 per mm.³ Hemogram was otherwise normal. Serologic tests for syphilis were negative. Blood chemistry profile demonstrated an alkaline phosphatase of 200 IU/dl (normal range 2.5-9.7), serum calcium of 10.6 mg%, and the serum phosphorus of 3.6 mg%. A Coombs' test was negative. Serum protein electrophoresis, quantitative immunoglobulins were all normal. The electrolytes were normal. Antinuclear antibodies were absent.

X-ray films of the skull, hands, and chest were normal. Liver-spleen scan confirmed splenomegaly. Bone marrow scan was done using Tc99 sulfur colloid according to a method previously described,⁴ and demonstrated diffuse and patchy decreased uptake and was thought to be compatible with marrow necrosis. A bone scan with Tc99 pyrophosphate revealed a very unusual feature of increased uptake throughout the costal cartilage, calvarium, and femurs. Brain scan with technetium methylene diphosphonate was normal. The x-ray films of soft tissue of the right thigh and knee indicated subcutaneous calcifications. A bone marrow aspirate revealed a mild increase in megakaryocyte number. There were adequate iron stores with no ring sideroblasts. The marrow biopsy demonstrated areas of hemorrhagic necrosis (see Figure 1) with fibrous reaction and new bone formation. There was no granuloma formation.

Cerebrospinal fluid studies were negative. The electroencephalogram showed generalized slowing without focal damage. Ophthalmological examination failed to reveal evidence of vasculitis or granulomatous lesions.

During hospitalization, she required heavy doses of haloperidol to control restlessness and agitation. Her course in the hospital was further complicated by skin ulceration in the medial aspect of both thighs. Biopsies were done and indicated panniculitis.

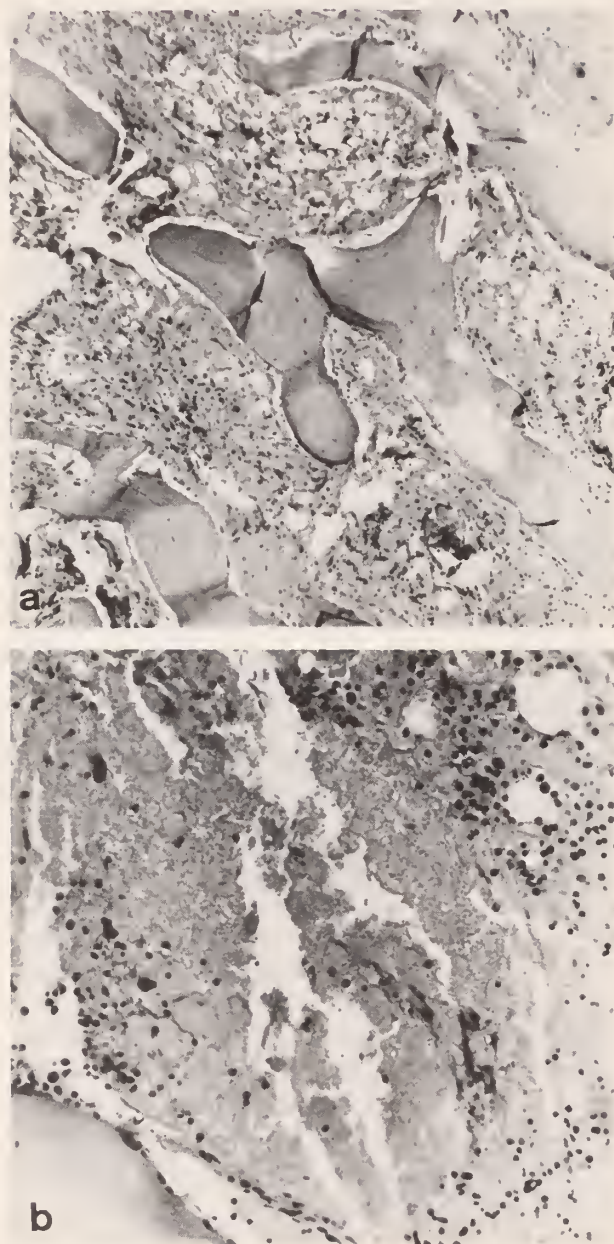


Figure 1a is a photomicrograph of bone marrow biopsy specimen. The marrow necrosis is seen within the interstices of bone trabeculae. It is characterized by disappearance of normal structure, karyorrhectic nuclei and the presence of a homogeneous acidophilic substance, as well as the heterogeneity of fat globules in the necrotic fat cells. Figure 1b is a higher magnification of marrow biopsy showing the homogeneous eosinophilic necrotic substance. The large nuclei are the nuclei of necrotic megakaryocytes. (a $\times 75$, b $\times 250$).

Three days following discontinuation of phosphate intake, calcium level rose to 12.5 mg%, and phosphorus level dropped to 2.6 mg%. Parathyroid hormone level at that time was 1,460 pg/ml with the upper normal being 300 pg/ml. Neck exploration was done and a left lower parathyroid adenoma weighing 3 gms and measuring 2.3 x 1.2 cm was removed.

Postoperatively, the patient gained her full normal mental capacity within three days and halperidol was no longer required. Postoperative hypocalcemia was corrected with 50,000 units of vitamin D twice a week. The spleen size gradually decreased. Three months after surgery, the spleen was no longer palpable and her hemoglobin level was 10.5 g/dl. The leg ulcerations were treated conservatively and completely resolved.

The bone marrow scan was repeated eight months postoperatively and showed no areas of diffuse patchy uptake as seen initially. It was interpreted as normal. Bone marrow biopsy showed moderate hypercellularity and complete resolution of the areas of hemorrhagic necrosis. Her most recent hemoglobin level was 12.5 g/dl with platelet counts and white cell counts as well as serum calcium and phosphorus levels being repeatedly normal.

Discussion

In this patient with hyperparathyroidism, necrosis of bone marrow was documented by bone marrow biopsy and bone marrow scan. To our knowledge, this is the first case in which the association of bone marrow necrosis and hyperparathyroidism was diagnosed antemortem by needle biopsy. When antemortem diagnosis of bone marrow biopsy has previously been made, the underlying diseases have usually been malignant disorders.⁴ Marrow necrosis occurred when serum calcium began to rise and serum phosphorus began to fall. It gradually resolved after parathyroidectomy which also led to normalization of other signs of hyperparathyroidism. This course, therefore, strongly suggested a causal relationship between hyperparathyroid lesion and marrow necrosis. A similar causal relationship can be invoked for the skin lesions and the splenomegaly, both of which rapidly resolved after the surgery.

Lesions similar to what was found in this patient's medial thighs have been described in patients with elevated serum calcium⁵ and have been produced in experimental animals by agents promoting deposition of calcium.⁶ Intravenous administration of phosphate causes widespread deposition of calcium salts in the circulation. This may also be seen with

oral phosphate administration. It is, therefore, reasonable to assume that the marrow necrosis, skin lesions, and splenomegaly were all precipitated by deposition of calcium salts in the microcirculatory bed resulting in hemorrhagic necrosis and subsequent inflammation. Supporting this assumption is the fact that all these lesions resolved with normalization of serum calcium.

Anemia in this patient also deserves a comment. Anemia is reported in 92% of patients with bone marrow necrosis which is invariably associated with erythroblastemia (presence of nucleated red cells in the circulation).^{2, 7} In this patient erythroblastemia was not seen, although buffy coat was not examined. Buffy coat examination has been advocated for recognition of erythroblastemia when only few nucleated red cells are present.⁷

It is of further interest that the bone marrow necrosis usually indicates a poor prognosis. When the antemortem diagnosis has been made, the median survival has been less than one month.² In this patient, however, the necrosis was apparently reversible after the surgical treatment of the underlying disease. This may be explained by the fact that in the previously reported cases, diagnosed antemortem, necrosis was secondary to malignant diseases. The widespread use of Jamshidi needle biopsy may help to elucidate other non-malignant diseases which can cause bone marrow necrosis and brighten this dismal outlook.

Summary

In a patient with hyperparathyroidism, bone marrow necrosis was documented with biopsy and radioisotope scan. Panniculitis of skin with ulceration and splenomegaly were also noted. All these findings subsided after the removal of parathyroid adenoma. These manifestations might have been caused by the precipitation of calcium salts in the microcirculatory beds including the marrow microcirculation. ★★★

1500 E. Woodrow Wilson Drive (39216)

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PROFILES

Roy D. Duncan, M.D. Trustee, District 9

A physician recruitment advertisement currently appearing in a number of medical journals uses the headline "Be a Physician and a Family Man — There's Time for Both."

Dr. Roy Duncan seems to be an embodiment of that philosophy. In an interview with JOURNAL MSMA, it became obvious that his focus is undeniably on his family — not only as he described his family's activities together, but also as he discussed his philosophy of family life. "We must develop our families," he said, emphasizing the importance of keeping the family as a focus and of actively working to develop and preserve that valuable rela-

tionship. It is particularly important, he stated, in the light of the particular strains that the profession sometimes places on families.

Family vacations twice a year are sources of pleasure for the Roy Duncan family, which includes wife Lynn, daughter Ashley (age 12) and son Clay (age 9). In winter they travel to places in Colorado, Utah or Montana for snow skiing. In summer, a favorite destination is Destin, Florida. This past summer they bought their first boat and enjoyed exploring areas around Pascagoula. The children took special delight in learning to water ski, Dr. Duncan related.

An interest in aviation that began when he was in the Air Force has grown into a favored hobby for Dr. Duncan. Whenever his schedule permits, he enjoys climbing into his small plane and spending some time viewing the Gulf Coast area from the air. For Dr. Duncan, flying is more than a hobby. "It is my therapy," he says, noting the unique combination of challenge and relaxation that flying offers.

Dr. Duncan is a native of Aberdeen. He received his B.S. degree from Millsaps College and his M.D. degree from the University of Mississippi School of Medicine. He interned and completed a residency in urology at Wilford Hall Air Force Base in San Antonio. In 1976 he joined Dr. Francis J. Selman, Jr. of Pascagoula in the practice of adult and pediatric urology.

The practice of medicine is something which he enjoys very much, Dr. Duncan said, citing in particular the opportunity to get to know people and help with their problems. He added that his special interests in the field of urology are stone disease and urinary incontinence.

Before his appointment to the MSMA Board of Trustees in 1980, Dr. Duncan served on a number of the association's councils and committees. He has been an active member of the Mississippi Foundation for Medical Care and has been an advocate of physician participation in utilization review. "All Mississippi physicians," he remarked, "must become involved in utilization review if quality care is to be preserved for the sick people of Mississippi."

Whenever his schedule permits, Dr. Roy Duncan enjoys spending some time in his small plane, viewing the Gulf Coast area from the air.



Fifth in a Series featuring members of the MSMA Board of Trustees

David R. Steckler, M.D. Trustee, District 8

The city of Natchez, one of the state's most popular tourist attractions, is appreciated for keeping alive its antebellum atmosphere. One of MSMA's trustees, Dr. David R. Steckler, is an active participant in preserving that community's rich heritage.

Although he is a native of Biloxi — another of the state's popular historical sites — Dr. Steckler has demonstrated a deep interest in the heritage of his adopted city, where he has lived since 1970. He is currently serving as president of the Natchez Historical Society, and he supervises the Natchez Museum.

His work in the community has extended beyond historical interest, however. He has served as a director of the Chamber of Commerce and of the Rotary Club. He has also been a member of the city's variance board and now is a member of the Natchez Recreation Council, which oversees the city's parks and recreation programs.

Dr. Steckler and his wife, Dale, have eight children ranging in age from three months to 14 years. They have been active in the local PTA, and Dr. Steckler is currently serving as president. He also is a coach in the elementary school football program and is vice president of the Natchez Swim Association.

Dr. Steckler enjoys all kinds of fishing, and is a regular participant in the MSMA deep sea fishing rodeo each year. He also enjoys hunting, particularly duck hunting.

His interests also include sailing. He has served as Commodore of the Delta Yacht Club at Lake St. John. Another of his special interests is farming, and he currently has 650 acres in soybeans and cotton.

Dr. Steckler received the B.S. degree from Millsaps College and the M.D. degree from the University of Mississippi School of Medicine. After interning at Mississippi Baptist Hospital in Jackson, he completed a residency in pathology at Jackson's University Medical Center.



One of Dr. David Steckler's special interests is deep-sea fishing.

His interest in pathology, he says, was stimulated when he worked in the laboratory at the VA Medical Center in Biloxi during summer vacations from college and medical school. He says that the opportunity to work with Dr. Horace Conti at that time was probably the biggest influence on his choice of specialty, but recalls that he developed an interest in becoming a physician when he was about ten years old.

Dr. Steckler's military service included 23 years in the Mississippi Army National Guard. He retired in 1979 with the rank of lieutenant colonel.

Prior to his election to the MSMA Board of Trustees in 1981, Dr. Steckler had served on a number of the association's councils and committees. He also served terms on the Mississippi State Board of Health and the Mississippi State Board of Medical Licensure. He is a member of the AMA and of Homochitto Valley Medical Society, and he also is a member and immediate past president of the Mississippi Pathology Association.

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes

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In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*



The President Speaking

Come to Our Seminar

SIDNEY O. GRAVES, JR., M.D.
Natchez, Mississippi

Eleven years ago the American Medical Association conceived the idea of a Leadership Conference, which was held in Chicago. There have been nine such meetings since then, and each year the quality of the program has improved and the number of participants has increased. At each conference, the speakers have been nationally known authorities on medical socio-economic subjects.

Last year your State Medical Association initiated a Leadership Conference. Although the attendance left much to be desired, the response of the members who attended encouraged us to have another "go at it" this year.

On Saturday, March 5, we will have a seminar on "Health Issues in the 80's," and on Sunday, March 6, we will have a Political Action Workshop. These sessions will be held at the Coliseum Ramada Inn in Jackson.

At the Saturday session, we will lead off with Dr. Alvin Tarlov, former chairman of the GMENAC, who will speak on "The Impending Doctor Glut." We will have a talk on "Coalitions in Health Care" by an executive of South Central Bell. He will tell us how this idea is working in Birmingham. We will also hear about "Individual Optional Plan" and "Third Party Reimbursement." At the luncheon, Dr. Harry Schwartz, editor of *Private Practice Magazine* will speak on "Health Care Today and Tomorrow."

In the afternoon session, we will have John Quincy Adams, professor of political science at Millsaps College, speak on "Voting Trends in Mississippi." We will also have Bill Minor, who will tell us about "Mississippi Politics 1983 — Diagnosis and Prognosis." There will be other interesting and informative talks with question and answer panels after both the morning and afternoon sessions.

On Sunday morning, we will have staff of the American Medical Political Action Committee tell us how to become more effective in the election process. The Sunday seminar will conclude with a luncheon which will feature a member of our congressional delegation.

I am not trying to say that the program that we have developed for March 5-6 is better than the AMA Leadership Conference, but I will say that this day and a half in Jackson will be just as informative to us as would three days at the Chicago Leadership Conference.

If you haven't done so, make your reservations now. This is a great opportunity to glean information that will be helpful to your profession, your association, and yourself.

Come to the seminar!

★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXIV, Number 2

FEBRUARY 1983

PMI Answers Public Demand and Demonstrates Professional Concern

Along with the growing public interest in health issues and medical self-care has come an increased demand from patients for information about the drugs they take. Physicians are being called on as never before to respond with a greater emphasis on patient education.

In order to provide physicians with printed drug information they can use to counsel and give to patients along with a prescription, the American Medical Association has launched its Patient Medication Instruction (PMI) program. A PMI sheet offers the patient general, easily-understood information on the purpose, use, and possible side effects of a medication, and also provides space for individualized instructions from the physician.

The AMA developed its PMI program as a voluntary, private sector alternative to the Food and Drug Administration's recently-rescinded mandatory Patient Package Insert (PPI) program. The AMA's goal is to help physicians help their patients understand why drugs are prescribed, thus enhancing the likelihood of compliance and thereby improving the effectiveness of therapy.

The PMI program assists individual physicians in fulfilling their responsibility to provide drug information to patients. The entire PMI sheet is presented in a manner that provides a balanced summary of anticipated benefits versus possible risks.

Physicians may order PMI sheets in pads of 100. On the cardboard back of each PMI pad is a list of generic and brand names of drugs falling within the class covered by the PMI, with instructions to the physician that the PMI covers only the drugs listed.

The PMI program is not intended as a substitute for the instruction on drugs that physicians give each patient. Neither is it an attempt to provide a legal instrument of informed consent or complete data. Rather, the program is meant simply to offer appropriate drug information in a manner that will

benefit the patient by augmenting discussion with the physician.

The AMA's Patient Medication Instruction program demonstrates professional concern about patients' participation in their health care. It shows a commitment to activities designed to promote the quality of medical care while addressing the cost of care. It is a private sector initiative to counter the regulation of the practice of medicine by inaugurating effective voluntary efforts.

Doctors who would like to request PMI samples or order blanks should write to AMA Order Department, PMI Program, 535 North Dearborn Street, Chicago, Illinois 60610. — C.L.M.

LETTERS

TO DR. DERRICK: Your little editorial that just appeared in the State Medical Journal (November issue) about our fees was very appropriate in my opinion. I have similar sentiments and have thought about putting them in writing, but my natural tendencies toward reticence and shyness have restrained me. Maybe you have opened the door for more of us to express ourselves on the subject. The practice of Medicine is not always easy, but it has so many satisfactions that we should not want to be over paid. I, too, hope we can exercise restraint in our charges and elevate our position of esteem by the public; perhaps also postpone the government having excuses to control us.

J. S. COVINGTON, M.D.
Meridian, MS

(Ed. Note: The following letter is one physician's response to an article on health care costs published in the November 1982 issue of JOURNAL MSMA. The

LETTERS / Continued

article, written by Michael Gartner, editor and president of the Des Moines Register and Tribune, was entitled, "But Doctor, What About My Financial Health?")

Dear Mr. Gartner: I certainly enjoyed reading a copy of your speech made to the Iowa Medical Society which was recently published in the Mississippi State Medical Association Journal. I too can assure you that I am very much interested in health care costs. To this end I began performing out-patient cataract surgery some 18 months ago. However, I have been aborted in many of my attempts along this line. Patients are continually denied reimbursement from their insurance companies because the procedure was done as out-patient rather than in-patient basis. This is in spite of the fact that the insurance company would save hundreds of dollars by the patients being out-patient rather than in-patient. For that reason we now have to advise our patients to check closely their insurance policies. If there is any question they have to spend the night in the hospital for no reason other than an insurer who denies out-patient charges.

It is unfortunate that many patients pay premiums for years only to have their claims denied because we saved the insurance company money and performed the procedure as an out-patient. I note that you point your finger at physicians for not controlling health care costs; however, you must realize we are simply part of the overall jungle. Often we are thwarted in our attempts to reduce costs because we must go along with the system. Can you expect us to be so

cold-hearted as to turn down a poor, old patient who has been paying his insurance claims and simply wants to spend the night in the hospital to get things paid. You and I both know it is much cheaper as an outpatient, but why doesn't the insurance company respond?

Another problem that we as physicians constantly deal with is that of lawyers and malpractice. I feel in my heart that 90% of the lab tests which are ordered and routine hospitalization are both unnecessary, unwarranted, dangerous and expensive. To this end I personally presented evidence to the medical staff showing the cost effective ratio of routine lab test on admission and have tried desperately to have my patients' surgery performed without these tests. It in no way helps the patient and is unnecessary expense not to mention the risks. It is not a problem of the administration wanting to make more money off the tests as the administration supports us in our efforts to reduce these costs. However, the medical staff is afraid of the liability if certain routine preoperative tests which have no value whatsoever to the patient are not done. They cite legal problems not medical problems as the reason for doing these tests.

Never the less, I have continued my struggle and next month will again present a presentation to the medical staff to try to do away with these unnecessary tests. Therefore, I would suggest as well as singling out physicians you single out insurance companies and lawyers as a significant factor in the rising costs of health care in this country. I assure you I will continue to do my part.

LYNN B. McMAHAN, M.D.
Hattiesburg, MS

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MEDICO-LEGAL BRIEF

Hospital's Contract Violates Antitrust Statutes

A hospital's exclusive contract with an anesthesiology group was an illegal tying arrangement, a federal appellate court in Louisiana ruled.

A board-certified anesthesiologist applied for admission to the medical staff of a hospital. In 1977, despite favorable recommendations by both the credentials committee and the medical staff executive committee, the hospital board voted to deny him staff privileges. The denial was based on an exclusive contract the hospital had with an anesthesiology group. The four anesthesiologists in the group supervised the nurse-anesthetists in the hospital's 13 operating rooms.

The rejected anesthesiologist then filed an action against the hospital, alleging violation of the Sherman Antitrust Act, the state antitrust law, the due process clause of the Fourteenth Amendment and another state law. A federal trial court dismissed the action, but the federal appellate court reversed. The trial court's definition of the geographical market was erroneous because nearly one-third of the patients from the area went to the hospital. This clearly gave the hospital sufficient market power to coerce purchase of anesthesiology services from the group.

The arrangement was an illegal tying arrangement in which users of the hospital's operating rooms were forced to use the hospital's chosen anesthesiology group. The hospital made a large profit from the arrangement because a small group of anesthesiologists supervised a larger group of lower paid anesthetists. However, the patients were billed for the services of an anesthesiologist.

Noting the anticompetitive effects of the exclusive contract, the court said that it prohibited competition from other groups and eliminated the surgeon's or patient's choice of anesthesiologist at the hospital.

"This opinion, the court concluded, "does not test the limits of access to staff privileges. Certainly, the staff size of each hospital is bounded by legitimate concerns of overcrowding, overtaxing of hospital personnel and resources, and the consequent decline in quality of patient care. In the instant case, however, it was not the size of the department which concerned the hospital board, but the profit which the current structure generated. In addition, the concerns which allegedly led to the implementation of the exclusive contract can be addressed by much less

restrictive alternatives. They furnish an illusory basis for depriving a physician of the right to practice his profession."

The court ordered the hospital to grant the anesthesiologist staff privileges and permit him to practice his chosen profession. — *Hyde v. Jefferson Parish Hospital District No. 2*, 686 F.2d 286 (C.A.5, La., Sept. 20, 1982)

Review A Book

The following books have been received. Members of MSMA interested in reviewing any of these volumes should address their requests to Editor, JOURNAL MSMA, P.O. Box 5229, Jackson, MS 39216. After submitting to the JOURNAL a review for publication, you may keep the books for your personal libraries.

Physician's Handbook: Twentieth Edition. Los Altos: Lange Medical Publications, 1982. \$12.00.

Current Medical Diagnosis & Treatment. Edited by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. Los Altos: Lange Medical Publications, 1982. \$26.00.

Current Pediatric Diagnosis & Treatment: Seventh Edition. Los Altos: Lange Medical Publication, 1982. \$26.00.

Current Obstetric & Gynecologic Diagnosis & Treatment: Fourth Edition. Edited by Ralph C. Benson, M.D. Los Altos: Lange Medical Publications, 1982. \$25.00.

Principles of Clinical Electrocardiography: Eleventh Edition. Edited by M. J. Goldman, M.D. Los Altos: Lange Medical Publications, 1982. \$15.00.

Basic and Clinical Pharmacology. Edited by Bertram G. Katzung, M.D., Ph.D., Los Altos: Lange Medical Publications, 1982. \$23.50.

Handbook of Poisoning: Eleventh Edition. Robert H. Dreisbach, M.D., Ph.D. Los Altos: Lange Medical Publications, 1983. \$11.00.

Clinical Cardiology: Second Edition. Edited by Maurice Sokolow, M.D. and Malcolm B. McIlroy, M.D. Los Altos: Lange Medical Publications, 1982. \$17.50.

THE LITERATURE

Book Review

Review of Medical Microbiology: Fifteenth Edition. Los Altos: Lange Medical Publications, 1982, \$17.00.

To review a book that has survived for over twenty-eight years through fifteen editions demonstrates what Francis Bacon meant when, in 1625, he wrote, "Critics are like brushers of noblemen's clothes." Lange's 15th edition of "Review of Medical Microbiology" has become through periodic refinements, an easily readable, attractive, and informative standard textbook. It is a real thoroughbred.

To the student of medicine, whether an enthusiastic neophyte or a grizzled clinician, who is undecided about which microbiology text to study or use for reference, I heartily recommend this publication. Its light-blue paperback cover has gained for it a degree of familiarity, its habitat being medical libraries, clinical laboratories, and physicians' offices. It may also be seen clutched in the hands of an infection control nurse, or being gently rocked in the arms of a sophomore medical student. It is affordable (\$17.00) but not cheap. Its lucid type is comfortable to read, the illustrations are adequate, if not suprasophisticated. The table of contents is logical, and the index is thorough and easy to use.

There is no voluminous appendix awaiting the reader at the end. References have been updated and wisely chosen.

The triumvirate of Drs. Jawetz, Melnick, and Adelburg has again applied its talents not only to treatment, pathogenesis, epidemiology, clinical findings, and antimicrobial chemotherapy to keep the clinicians interested, but also has included descriptions of laboratory testing, discussions of physical and chemical properties of organisms, along with the in-depth study of cell structure, microbial genetics and metabolism.

The book has not been increased in size! Deletions and condensations have allowed new subjects to be added without increasing the girth of the book. New topics include sections dedicated to recombination in eukaryotic micro-organisms, transposable elements, and principles of molecular cloning of DNA. Besides genetics, new sections include paragraphs on urinary antiseptics, anti-viral drugs including interferon, specific immunological unresponsiveness, the Enterobacteriaceae, and the now-combined *Proteus*-*Providencia* group.

The meat of the initial chapters is basic science. Chemical and biological processes are lucidly taught with the aid of illustrations, diagrams, and photographs. These early chapters constitute an excellent review for those whose graduations predate the early 1960's. Even ecological requirements are explained.

As in most standard microbiology texts, organisms are discussed by category. This includes definition, morphology, pathogenesis, pathology, clinical findings, diagnostic laboratory tests, immunity, and treatment.

The large amount of text donated to viruses was a pleasant surprise and should be read by practitioners who are uncertain, or have a weak grasp, of the essentials of virology. This chapter covers the general properties of viruses, wends its way to diagnosis, goes into a discussion of the familiar, individual viruses and diseases, and ends with a chapter on oncogenic viruses.

Medical parasitology closes the text, appearing almost as an afterthought. Eleven pages of illustrations salvage some respectability for the extraordinary topic.

I recommend this 533-page text to fulfill the needs of practitioners for review or as a resource text. Its completeness makes it an excellent comprehensive reference. It is a working book, and is meant to be worn out. Like a dirty book, it will never gather dust.

EDWARD C. KRECKER, M.D.
VA Medical Center
Biloxi, MS 39531

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MEDICAL ORGANIZATION

MSMA's 1983 Legislative Proposals Include Malpractice Law Reform

The 1983 Regular Session of the Mississippi Legislature got underway January 4 in the newly renovated Capitol Building in Jackson. Included among the many health-related bills before the legislators are several which the MSMA is sponsoring. Those bills deal with the subjects of malpractice reform, changes in the state's implied consent law, and mandatory child restraints.

Six MSMA-sponsored bills calling for malpractice tort reform were introduced in the House and Senate. They called for the following measures: (1) to require public and private hospitals to obtain liability insurance; (2) to provide for a waiver of the physician-patient privilege when a claim is made; (3) to eliminate the statement of damages claimed by a plaintiff in a malpractice suit from the complaint; (4) to shorten the statute of limitation in actions by minors against health care providers; (5) to require a certificate of merit executed by the plaintiff's attorney to be filed in any action for professional negligence by a physician; and (6) to allow evidence of third party payments in mitigation of damages in actions (collateral source rule).

Two of those bills (the certificate of merit and collateral source) failed to pass the Senate Judiciary Committee; but the other four will appear before the full Senate. At press time three of the remaining four bills, having passed House subcommittee hearings, were scheduled to appear before the full House Judiciary B Committee.

More than 25 bills dealing with the subject of drunken drivers were introduced in the Legislature this year. MSMA supports five changes intended to strengthen the state's current implied consent law: (1) to make blood alcohol concentration of 0.10% conclusive proof of driving under the influence; (2) to make it mandatory for drivers to take a blood alcohol test at the discretion of the arresting officer; (3) to restrict the time limit on supersedeas appeals from D.U.I. convictions by justice of the peace and city courts; (4) to significantly increase the penalty for driving with a license suspended or revoked from a D.U.I. conviction; and (5) to increase the legal drinking age from 18 to 21.

Another MSMA-sponsored bill deals with child restraints. Having already passed the House, the bill

requires that children under the age of 3, while being transported on Mississippi roads and highways, must be in an appropriate, federally-approved, child restraint device.

The MSMA, on action of the Council on Legislation, has endorsed a number of other bills now receiving the attention of the legislators. Included among that list are S.B. 2305, a bill providing for health insurance claims to be paid or denied within 15 days and S.B. 2387, allowing persons to authorize withdrawal of life-sustaining mechanisms from their body. Another bill, H.B. 311, calling for the transfer of methaqualone from Schedule II to Schedule I, has the support of the MSMA. The association also has supported a bill extending the Medicaid "cap" by \$4 million. That is the amount of state funds needed to allow the limited medically needy program to be put into effect. The program would provide prenatal and delivery services among other benefits to married pregnant females who are currently not covered. Enabling legislation passed the Senate Public Health and Welfare Committee, but action on the appropriation bill will receive the attention of the full Senate later.



Legislators, staff, and visitors to the Capitol Building can receive medical attention at MSMA's Emergency Medical Care Unit, staffed by Mavis Barlow, R.N. and volunteer Doctors of the Day. Rep. Tommy Brooks of Tupelo, at right, is pictured with Mrs. Barlow and Dr. Louie F. Wilkins, Doctor of the Day. When the EMCU opened this year, in new quarters on the ground floor of the newly-renovated Capitol Building, it marked the 19th consecutive year of operation for the unit.

Medical Education Report Shows Few Changes

For the past several years enrollment at the University of Mississippi School of Medicine has remained relatively constant, a situation that apparently is repeated in medical schools across the nation.

According to the American Medical Association's "82nd Annual Report of Medical Education in the United States," there were 66,485 medical students enrolled in schools across the country last year, an increase of only 1.5 percent over the previous year. First-year enrollment increased by less than one percent.

Figures from the University of Mississippi School of Medicine show that at this time last year there were 596 medical students enrolled. That represents no significant change over the past four years, according to Dr. Carl Evers, associate dean. First-year enrollment figures are constant, with the medical school admitting 150 new students each year.

The number of Mississippi applicants for medical school is also relatively constant, usually numbering between 360-385. Nationwide, the number of applicants last year (36,727) increased slightly over the previous year. The AMA report notes that it was the

first increase in the number of applicants since 1978, but still 13.8 percent less than the peak year of 1974-75.

The number of women entering medical school continues to grow. For the 1981-82 academic year, there were 5,343 women in the entering class, an increase of 7.5 percent over the preceding year, representing almost 31 percent of all entering students. This is more than three times the percentage of women entering medical school in 1969, when enrollment of women in medicine began to increase. More than 45 percent of women applicants were admitted.

The number of women students is increasing at the University of Mississippi medical school as well. During the 1981-82 academic year, 117 of the 596 students were women. Currently, total enrollment stands at 586, of which 130 are women.

The number of minority students enrolled in medical schools in 1981-82 was 9,303, according to the AMA report. At the Mississippi medical school, the number of minority students totaled 45. That number included 30 black, three Hispanic, one American Indian, and 11 students of Asian/Pacific origin.

The survey on medical education, published in the December 24 issue of JAMA, is introduced by "Future Directions for Medical Education," a report by the AMA Council on Medical Education. This report, adopted by the AMA House of Delegates in June, 1982, calls for changes needed to achieve a balance between generalism and specialism in educating future physicians.

Surgical Group Honors Dr. Lawrence W. Long



Dr. Lawrence W. Long of Jackson displays a plaque presented to him by the U.S. Section of the International College of Surgeons. Dr. Long served the organization in a number of posts, including chairman of the board of trustees, and the award was presented "In recognition of his meritorious service, loyal and unselfish devotion, untiring efforts and personal sacrifice."

Medical School Establishes Division of Emergency Medicine

A Division of Emergency Medicine has been established in the School of Medicine Department of Medicine at the University of Mississippi Medical Center.

Creation of the new division was approved by Board of Trustees, State Institutions of Higher Learning, in December. Department of Medicine faculty staff the University Hospital emergency room on a full-time basis. The new division will enable the Department of Medicine to meet its responsibilities for patient care and teaching emergency medicine more effectively.

The University's emergency room will be moved to the acute services wing this winter. The addition will be dedicated in public ceremonies on February 17.

UMC Announces Faculty Appointments

The University of Mississippi Medical Center has added six new faculty members to the medical and centerwide faculties.

Dr. Norman C. Nelson, UMC vice chancellor for health affairs, announced the appointments, following approval by the Board of Trustees, State Institutions of Higher Learning.

In the School of Medicine, Dr. Melvin Prosen was named associate professor of psychiatry and human behavior and Dr. Nancy Caroline Hobson appointed an instructor in pediatrics (psychology). Dr. Sue Mary Palmer was named assistant professor of obstetrics and gynecology. Dr. Richard Harold Streiffer was named assistant professor of family medicine.

Joining the centerwide faculty were Dr. Kunio Gonmori, visiting instructor in pharmacology and toxicology, and Dr. Steven Gary Patrick Hardy, assistant professor of anatomy.

Dr. Prosen has served as director of psychiatry inpatient services at Rush-Presbyterian St. Luke's Medical Center in Chicago since 1981 and as its director of psychiatry residency training since 1975. He earned the M.D. degree at the University of Manitoba.

Dr. Hodson received the Ph.D. degree from Mississippi State University and has been a psychologist at the Jackson Learning Resource Center since 1981. She was also a staff psychologist at "Wings" Gymnastics in Boise, Idaho, and an assistant professor of guidance, counseling and special education at Delta State University.

Dr. Palmer, who earned the M.D. degree at the University of Arizona, has been assistant professor of obstetrics and gynecology at the Harbor/UCLA Medical School since 1981.

Dr. Streiffer has been in private practice in Collins since 1980. He earned the M.D. degree at the Louisiana State University Medical Center.

Dr. Gonmori earned the Ph.D. degree at the Akita University School of Medicine, where he was also an instructor of forensic medicine. He also has been a research assistant in pharmacology at UMC.

Dr. Hardy earned the Ph.D. degree at Virginia Commonwealth University Medical College of Virginia and has been a postdoctoral fellow at the Emory University School of Medicine since 1981. He was a staff physical therapist at UMC and has been an assistant professor of community health in the division of physical therapy at the Emory University School of Medicine since 1980.

Funeral Services Held For Dr. Temple Ainsworth

Funeral services for Dr. Temple Ainsworth, former MSMA president, were held January 11 in Jackson. Dr. Ainsworth died January 9 at Mississippi Baptist Medical Center.

A native of Bay Springs, Dr. Ainsworth received his bachelor's degree from the University of Mississippi. He obtained his medical degree from the University of Virginia in 1926.

After completing his internship and training in urology at the University of Virginia Hospital, he began his private practice in Jackson. He was the first physician in Mississippi to be certified by the American Board of Urology. After becoming a member of the Southeastern Section of the American Urological Association, he was elected to its presidency in 1952.

A fellow of the American College of Surgeons, he served as a governor of the College and president of its Mississippi Chapter. He was a member and former president of Central Medical Society. He was a member and former president of the American Urological Association, and he was also a member of the Society of Pediatric Urologists, the American Association of Clinical Urologists and Societie Internationale D'Urologie.

Dr. Ainsworth served as one of three members of the Medical Advisory Board formed to assist the state College Board in founding the University of Mississippi School of Medicine as a four-year institution. From 1954 to 1968, he served as the school's clinical professor and chairman of the Division of Urology.



Dr. Ainsworth

DEATHS

BRAMLETT, EUGENE V., Oxford. Born Oxford, MS, June 24, 1909; M.D., University of Pennsylvania School of Medicine, Philadelphia, 1933; interned Miseracordia Hospital, Philadelphia, PA, one year; died Dec. 8, 1982, age 73.

POSTGRADUATE CALENDAR

March 10-12

POSTGRADUATE SURGICAL FORUM X
Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery and the UMC Division of Continuing Health Professional Education.

Coordinator: Dr. J. Harold Conn, professor of surgery; and chief, Division of Surgery, Veterans Administration Medical Center.

A guest faculty will join UMC faculty members in presenting sessions on controversial problems in surgery, endocrine surgery, vascular surgery, surgical oncology, and biliary-pancreatic surgery. Registrants are invited to bring problem cases, along with x-rays, to present for discussion during conferences. Fee: \$275. Credit: 22 credit hours in Category I of the Physician's Recognition Award of the AMA.

March 17-18

MEDICINE IN THE OLD SOUTH
University Medical Center and Old Capitol, Jackson

Sponsored by the University of Mississippi Medical Center for the Study of Southern Culture and the University of Mississippi Medical Center Division of Continuing Health Professional Education.

Coordinator: Ann Abadie, Associate Director, Center for the Study of Southern Culture, University of Mississippi.

This 1983 Barnard-Millington Symposium will bring together historians of American medicine and of the South as well as scholars in folklore and religious studies to view the state of medicine in the Old South against the backdrop of the rest of the nation. Authors, commentators and scholars from throughout the nation will participate in the eight sessions. Fee: None. Credit: to be determined.

March 24-25

FIFTH ANNUAL NEUROLOGY SPRING SYMPOSIUM
Medical Center Holiday Inn, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Neurology, the Veterans Administration Medical Center

Neurology Service and the UMC Division of Continuing Health Professional Education.

Coordinator: Dr. Shri K. Mishra, associate professor of neurology.

This two-day course provides an indepth review of selected system disorders affecting the central nervous system, the peripheral nervous system and the muscle. Clinical aspects of various neurological manifestations of systemic disorders will be addressed. Fee: \$150. Credit: 13 contact hours AMA Category I.

March 26

PHOTOGRAPHY UPDATE FOR EDUCATION AND SLIDE PROGRAMS
Keesler Air Force Base, Biloxi

Sponsored by the University of Mississippi School of Dentistry, the UMC Division of Continuing Health Professional Education, and Keesler Air Force Base Medical Center.

Coordinator: Dr. William Akerly, Associate Professor of Restorative Dentistry.

Close-up photography will be taught, as well as planning and producing slide presentations for teaching or personal use. Registrants will participate by making and coloring slides for projection. Fee: \$60. Continuing education credit is offered.

For more information on continuing education, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: 987-4914.

The Scientific Assembly MSMA's 115th Annual Session Royal d'Iberville Hotel, Biloxi

Friday, May 13, 1983

Section on Family Practice
Section on Surgery
Section on Medicine
Section on Ob-Gyn
Section on Pediatrics
Section on Preventive Medicine

Saturday, May 14, 1983

Section on EENT
Section on Anesthesiology
Section on Pathology
Section on Psychiatry
Section on Radiology
Section on Urology
Section on Dermatology
Section on Orthopedic Surgery

PERSONALS

WILLIAM J. ANDERSON of Jackson has been named a fellow in the American College of Chest Physicians.

ORLANDO ANDY of UMC presented papers at the annual meetings of the Eastern Association of Electroencephalographers in New York and the Pavlovian Society in St. Petersburg, Florida.

WILLIAM BILLINGTON of West Point was recently elected chief of staff of Ivy Memorial Hospital.

RICHARD E. BUCKLEY of Biloxi was selected Alumnus of the Year by the Harrison County chapter of the Mississippi State University Alumni Association.

JOHN COOK of Brandon was recently elected chief of staff at Rankin General Hospital.

ROBERT CURRIER of UMC spoke at a recent meeting of the Amyotrophic Lateral Sclerosis Society of America in Kansas City, Missouri.

EDGAR DRAPER of UMC attended the American Psychiatric Association meeting in Washington, DC as president-elect of the district branches.

BARBARA A. FLEETWOOD and L. H. BRANDON of Starkville announce their association in practice at the Family Clinic, 501 Hospital Road.

JAMES HARDY of UMC presented a paper at the Southern Surgical Association meeting in West Palm Beach, Florida.

WILLIAM K. HARPER of Jackson has been named a fellow of the American College of Chest Physicians.

WILLIAM S. HARRIS has associated with the Vicksburg Clinic for the practice of gynecology and obstetrics.

LUCIEN HODGES of Jackson was elected director-at-large of the American Association of Neurosurgeons during the society's annual meeting in Hawaii.

JEFF HOLLINGSWORTH of Jackson has been named a fellow of the American College of Chest Physicians.

JOHN JACKSON of UMC presented grand rounds at the Delta Medical Center in Greenville recently.

SAMUEL JOHNSON of UMC was site visitor at the University of Missouri in Columbia.

HERBERT LANGFORD of UMC attended an editorial

review and steering committee meeting of the Hypertension Detection and Followup Program in Houston, Texas.

GILBERT MASON of Biloxi was recently elected president of the medical staff of Biloxi Regional Medical Center.

JOHN MORRISON of UMC served as a member of the steering committee for the Antenatal Steroid Therapy Trial in Miami, Florida.

ANDREW J. MYRICK announces the opening of his office for the practice of medicine and surgery at 609 Van Buren Avenue in Oxford.

WILLIAM F. PONTIUS of Biloxi has been re-elected chief of staff at Biloxi Regional Medical Center.

SESHADRI RAJU of UMC presented a paper at the Southern Surgical Association meeting in West Palm Beach, Florida.

GORDON W. SLUIS has associated with the Vicksburg Clinic for the practice of pediatrics.

ROBERT SMITH of UMC was moderator at a symposium on the role of fibrinolytic bleeding in clinical practice in Miami, Florida, in December.

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NEW MEMBERS

BOWMAN, ROBERT P., Greenville. Born Wooster, OH, Aug. 19, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1967; interned Fitzsimmons Army Medical Center, Denver, CO, one year; medicine residency, same, 1968-71; fellowship in oncology and hematology, Walter Reed Army Medical Center, Washington, DC, 1971-73; elected by Delta Medical Society.

COLTHARP, JAMES R., Hattiesburg. Born Columbus, MS, Sept. 15, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned Charity Hospital, New Orleans, one year; otolaryngology residency, University Medical Center, Jackson, MS, 1979-80; otolaryngology residency, University of Colorado, Denver, 1980-82; elected by South Mississippi Medical Society.

DAPREMONT, EDGAR M., JR., Gulfport. Born New Orleans, LA, Oct. 8, 1947; M.D., Tulane University School of Medicine, New Orleans, 1973; interned Wilford Hall, USAF Medical Center, San Antonio, TX, one year; ophthalmology residency, Walter Reed Army Medical Center, Washington, DC, 1976-79; elected by Coast Counties Medical Society.

DARSEY, KENT ALLEN, Collinsville. Born Natchez, MS, March 19, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned University of Tennessee Medical Center, Memphis, one year; family medicine residency, University Medical Center, Jackson, 1980-82; elected by East Mississippi Medical Society.

FLEETWOOD, BARBARA ANN, Starkville. Born New London, CT, June 14, 1949; M.D., Dalhousie Medical School, Halifax, Nova Scotia, Canada, 1974; rotating internship, Halifax, Nova Scotia, Canada, one year; elected by Prairie Medical Society.

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FURR, MACK C., Jackson. Born Brookhaven, MS, May 22, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and medicine residency, University Medical Center, Jackson, MS, 1979-82; elected by Central Medical Society.

HAICK, ALEXANDER J., JR., Jackson. Born Jackson, MS, Nov. 19, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned Vanderbilt University Hospital, Nashville, TN, one year; general surgery residency, same, 1978-79; general surgery residency, University Medical Center, Jackson, MS, 1979-82; elected by Central Medical Society.

HAYS, MARTHA A., Gulfport. Born Gulfport, MS, Jan. 20, 1925; M.D., Louisiana State University School of Medicine, New Orleans, 1948; interned Charity Hospital, New Orleans, one year; pediatric residency, Louisiana State University, New Orleans, 1949-51; elected by Coast Counties Medical Society.

HILL, JULIAN B., JR., Tupelo. Born Corinth, MS, Sept. 25, 1951; M.D., Tulane University School of Medicine, New Orleans, 1977; interned University of Texas Health Science Center, San Antonio, one year; medicine residency, same, 1978-80; fellowship in oncology, National Institute of Health, 1980-82; elected by Northeast Mississippi Medical Society.

JAMES, MAURICE, Jackson. Born Canton, MS, Dec. 22, 1949; M.D., Columbia University College of Physicians and Surgeons, New York, NY, 1975; interned Harlem Hospital-Columbia University Affiliate, New York City, one year; ophthalmology residency, same, 1976-79; fellowship, Vanderbilt University, Nashville, TN, 1979-80; elected by Central Medical Society.

KENNERLY, WILLIAM PAUL, Biloxi. Born Indianapolis, IN, March 17, 1953; M.D., Indiana University School of Medicine, Indianapolis, 1977; interned Methodist Hospital, Indianapolis, one year; general surgery residency, same, 1979-82; elected by Coast Counties Medical Society.

HILL, FRANK S., JR., Columbia. Born Omaha, NE, May 6, 1935; M.D., University of Mississippi School of Medicine, Jackson, 1967; interned University Medical Center, Jackson, one year; radiology residency, same, 1968-71; elected by South Mississippi Medical Society.

PARKER, PAUL HARMON, Jackson. Born Meridian, MS, Dec. 8, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned University Medical Center, Jackson, one year; pediatric residency, same, 1976-78; pediatric gastroenterology fellowship, Vanderbilt University Hospital, Nashville, TN, 1979-81; elected by Central Medical Society.

PATEL, R. B., Jackson. Born Dar-Es-Salaam, Tanzania, Jan. 13, 1943; M.D., University of Baroda Medical School, India, 1967; interned Medical School Hospital, University Baroda, India, 1968-69; intern in internal medicine, same, 1969-69; interned radiology, same, July 1969-December 1969; radiology residency, Elyria Memorial Hospital, OH, 1973-75; radiology residency, University of Virginia Medical Center, Charlottesville, 1975-77; radiologic pathology, AFIP, Washington, DC, May-June 1976; elected by Central Medical Society.

PENDER, EMILY S., Cleveland. Born Greenville, MS, July 31, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned University Medical Center, Jackson, one year; elected by Delta Medical Society.

PENNEBAKER, JAMES B., Hattiesburg. Born Agricola, MS, July 20, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned University Medical Center, Jackson, one year; medicine residency, same, 1970-73; rheumatology fellowship, University of Texas, Southwestern Medical School, Dallas, 1974-76; elected by South Mississippi Medical Society.

ROSS, RANDOLPH J., Hattiesburg. Born Coronado, CA, April 7, 1950; M.D., Tulane University School of Medicine, New Orleans, 1975; interned Ochsner Foundation Hospital, New Orleans, one year; urology residency, same, 1976-80; pediatric urology fellowship, Cleveland Clinic Foundation, 1980-81; elected by South Mississippi Medical Society.

SEGREST, DAVID R., Jackson. Born Pascagoula, MS, June 30, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned Denver Presbyterian Hospital, Denver, CO, one year; ophthalmology residency, University of Colorado Health Sciences Center, Denver, 1978-81; oculo-plastic and orbital fellowship, University of Wisconsin and Davis-Deuhr Eye Association, Madison; elected by Central Medical Society.

NEW MEMBERS / Continued

SMITH-VANIZ, GEORGE T., Jackson. Born Cleveland, MS, June 22, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned University Medical Center, Jackson, one year; medicine residency, same, 1973-75; gastroenterology fellowship, Ochsner Clinic, New Orleans, 1975-77; elected by Central Medical Society.

STRINGER, W. LYNN, Jackson. Born Jackson, MS, July 22, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned North Carolina Baptist Hospital, Winston-Salem, one year; general surgery residency, same, 1976-77;

neurosurgery residency, same, 1977-81; microvascular neurosurgery, University of Western Ontario, January-June 1982; elected by Central Medical Society.

TAYLOR, MAX ROBERT, JR., Jackson. Born Jackson, MS, Sept. 29, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned University Medical Center, Jackson, one year; medicine residency and infectious disease fellowship, same, 1977-80; elected by Central Medical Society.

WILLIAMS, CHARLES H., Jackson. Born Jackson, MS, July 17, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned Spartanburg General Hospital, Spartanburg, SC, one year; family practice residency, same, 1979-81; elected by Central Medical Society.

PLACEMENT SERVICE

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Situations Wanted

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PATHOLOGIST-ONCOLOGIST seeks practice location. Frank P. Urso, M.D., P. O. Box 1149, Akron, OH 44301.

FAMILY PRACTICE resident seeks practice location in July 1983. Contact John D. Sites, M.D., 2002 Philip Dr., Muncie, IN 47302.

ANESTHESIOLOGIST seeks to relocate in state in solo, group or institutional practice. Contact M. T. Olivo, Jr., M.D., Box 794, Oxford, MS 38655.

SURGEON seeks location with established group in small city. Currently service as chief surgical resident at Ochsner Foundation Hospital. Available July 1983. Contact Thomas C. Kelly, M.D., 1516 Jefferson Highway, New Orleans, LA 70121.

PEDIATRICIAN seeks practice location in central or Gulf Coast area upon completion of residency in July 1983. Contact Steven D. Eggen, M.D., Alton Ochsner Medical Foundation, 1516 Jefferson Highway, New Orleans, LA 70121.

PATHOLOGIST seeks position in community hospital setting upon completion of residency in June 1983. Contact Robert J. Sinnenberg, M.D., Box 662 MCV Station, Medical College of Virginia, Richmond, VA 23298.

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of ampicillin resistance in
Haemophilus influenzae

Ampicillin Resistant
Haemophilus influenzae

H. influenzae

S. pneumoniae

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceflor® (cefalor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceflor.

Contraindication: Ceflor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: **General Precautions**—If an allergic reaction to Ceflor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceflor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceflor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceflor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinites® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceflor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceflor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceflor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceflor.⁷

Ceflor®

cefalor

Pulvules®, 250 and 500 mg

hour. The effect on nursing infants is not known. Caution should be exercised when Ceflor® (cefalor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceflor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis, and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceflor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome. Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

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*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

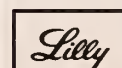
Note: Ceflor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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- Studied in over 200 clinical trials involving over 10,000 patients.¹³
- During long-term therapy, which is seldom required, periodic blood, kidney and liver function tests should be performed.
- Contraindicated in patients who are pregnant or hypersensitive to flurazepam.
- Caution patients about drinking alcohol, driving or operating hazardous machinery during therapy.



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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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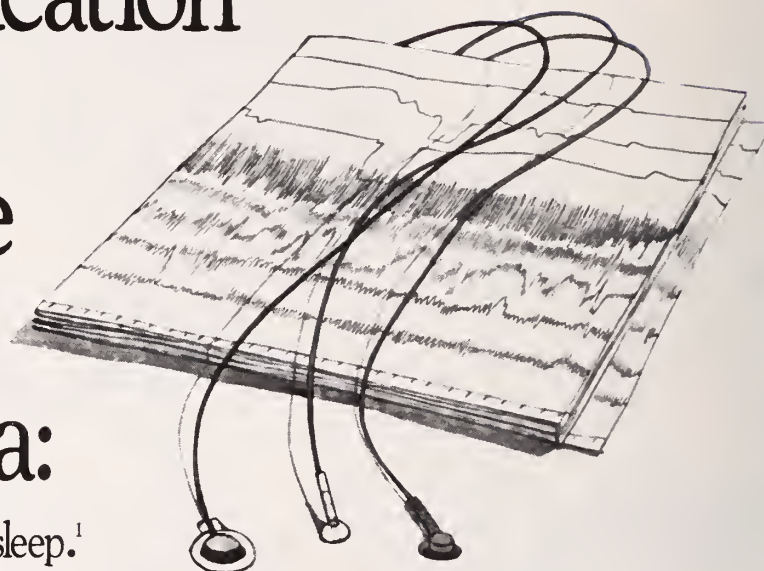
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The medical staff includes a large number of psychiatrists in private practice in the Jackson area. A toll-free number, 1-800-962-2180, has been established at the hospital for referral service to physicians on the active medical staff.

Physicians who have patients who would benefit from the type of treatment approach offered by Riverside may obtain referral information by contacting the Director of Admissions.

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NEWSLETTER

March 1983

Dear Doctor:

Medical offices throughout the state are now training new workers under a program of the Mississippi Employment Security Commission, and are realizing financial advantages in return. The On-The-Job Training Program helps employers by paying some of the expenses incurred when training new employees. For example, training a medical records clerk with an hourly wage of \$4.50 can save the employer \$1,440.00 under the program.

Similar savings may be realized in the training of receptionists and secretaries. Employers may also qualify for a tax credit on these employees after training is complete. For information about specific requirements and benefits, contact local employment offices of the Employment Security Commission.

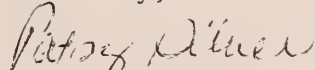
A new National Disciplinary Information System (NDIS) was launched recently by the Council of State Governments. Some 25 states have expressed an interest in joining the system, which will monitor actions against physicians, nurses, and other licensed professionals. NDIS will handle between 2,000 and 3,000 medical and non-medical disciplinary actions annually.

All persons at high risk for hepatitis B should receive hepatitis B vaccine, according to an editorial in the Feb. 7 issue of JAMA. After examining questions regarding the safety of human plasma used for manufacturing the vaccine, the JAMA commentary concluded that "it is clear at this point that the known risk of hepatitis B for persons in high-risk groups exceeds the risk of vaccine-induced infection by a theoretical transmissible agent."

An average of 91.4% of patient care physicians had hospital admitting privileges in 1982 - a decline of 2.7% in five years, the AMA Socioeconomic Monitoring System reports. The medical and surgical specialties had the highest level of physicians with admitting privileges (97.4% and 97.0% respectively) and the least decline (0.3% and 1.9%). Some 90.5% of MDs in general and family practice had admitting privileges -- 2.2% less than in 1977.

This issue of Journal MSMA includes an outline of preliminary plans for the association's big 115th Annual Session, May 11-15. Watch for the complete program in the April issue. Next month's issue will also feature publication of the Second Annual James Grant Thompson Memorial Lecture, "The Shroud of Turin: A Pathologist's Viewpoint."

Sincerely,



Patsy Silver
Managing Editor

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Reference: 1. Sheu YS, Ferguson JA, Cooper JR: *Evaluation of the Abuse Liability of Diethylpropion, Phendimetrazine, and Phentermine*, unclassified document, ADAMHA, HHS, Office of Medical and Professional Affairs, NIDA, 1980, pp 10-15.

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CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program.

Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.

Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.

Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.

Allergic: Urticaria.

Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.

Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phentolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdosage.

DOSAGE AND ADMINISTRATION: Since Melfiat® 105 (phendimetrazine tartrate) 105 mg is a slow release dosage form, limit to one slow release capsule in the morning. Melfiat® 105 (phendimetrazine tartrate) is not recommended for use in children under 12 years of age.

HOW SUPPLIED: Each orange and clear slow release capsule contains 105 mg phendimetrazine tartrate in bottles of 100. NDC 0063-1082-06.

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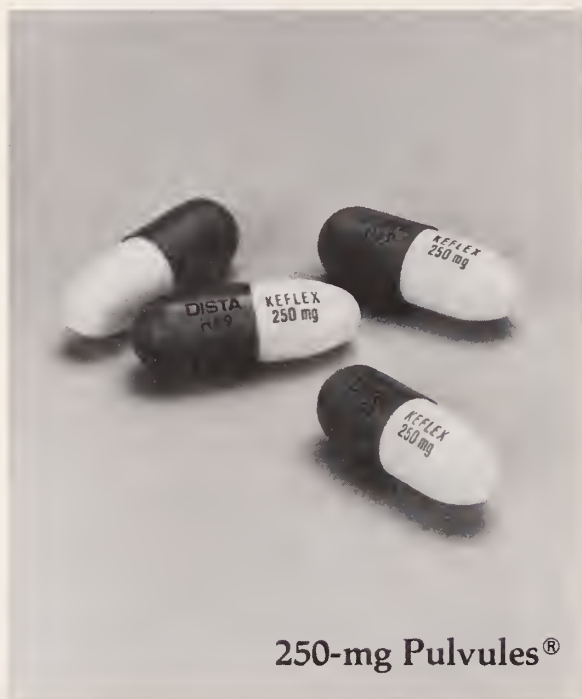


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DATELINE

Measles Reported
In Meridian

Jackson, MS - Three confirmed cases of measles - the first in the state since 1980 - have been reported to the State Health Department from Lauderdale County.

None of the children (ages 14, 16 and 12 months) had yet been immunized, and all three attended a day care center in Meridian. The source cannot be determined, and the health department urges physicians in the area and other areas to increase the level of suspicion for measles.

1982 Medical Costs
Exceed Overall CPI

Washington, DC - The cost of medical care increased 11% last year, or nearly three times as much as the overall consumer price index. The all-items CPI rose just 3.9%, the smallest increase in a decade. The 11% inflation rate in the health care field was the third highest since the government began reporting on medical costs in 1935. The rate was 12.4% in 1974 and 12.5% in 1981. Some physicians and other providers held down fees in 1982, producing a slight decline.

Uniform Coding System
Based on CPT-4

Chicago, IL - Medicare and Medicaid will use the American Medical Association's CPT-4 to launch a national uniform coding and nomenclature system for reporting medical services, according to an agreement signed last month by AMA Executive Vice President James H. Sammons, M.D., and Secretary of Health and Human Services Richard Schweiker. The agreement gives the HCFA unrestricted, royalty-free use of the copyrighted CPT-4.

Health Planning
Repeal Sought

Washington, DC - Last month another bill to repeal the Health Planning and Resources Development Act of 1974 was introduced in the Congress, and was referred to the House Energy and Commerce Committee. HR 1358 is similar to a repeal bill introduced last year which ran into difficulty due to opposition of Health Subcommittee Chairman Henry Waxman. The bill's author says the health planning program has "failed miserably in achieving the goals established for it."

Nursing Shortage
Apparently Over

Washington, DC - The widespread nursing shortage of the 1960s and 1970s largely has disappeared, reports the Institute of Medicine of the National Academy of Sciences. During a two-year study the institute found geographic and professional areas where nurses were in short supply, but concluded that there is "not a significant national shortage," and predicted growth in both supply and demand in the profession.

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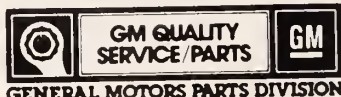
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For Oral Use

INDICATIONS AND USAGE: I. **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: **Excessive Hypotension:** Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: **General:** **Hypotension:** Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LOH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NOC 0069-2600-66), 300 (NOC 0069-2600-72), and unit dose (10x10) (NOC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received not all patients will respond to Procardia nor will they all respond to the same degree.

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[] as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks, taking fewer nitroglycerin tablets, doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

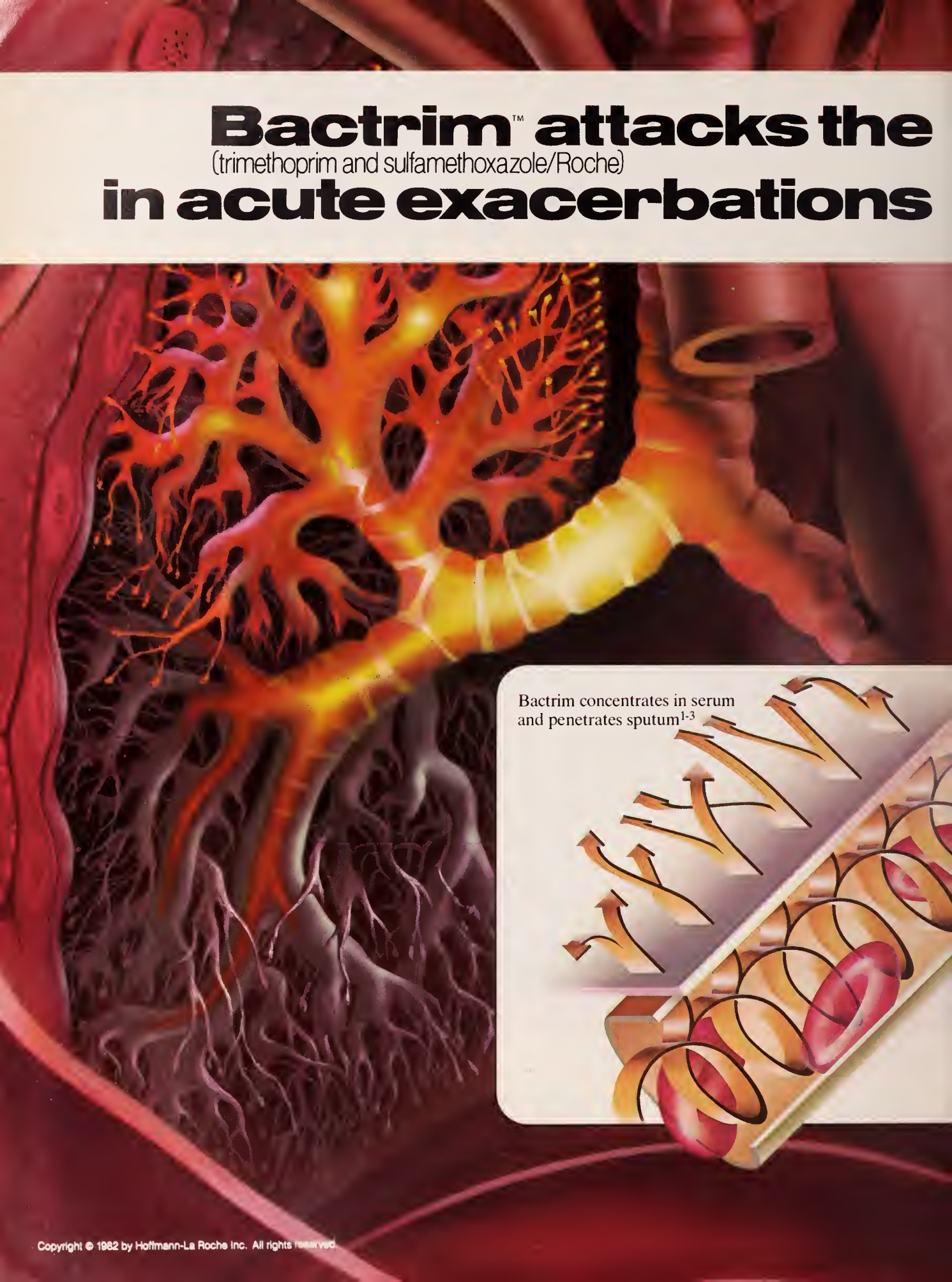
* Procardia is indicated for the management of:

- 1) Confirmed vasospastic angina.
- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

PROCARDIA[®] **(NIFEDIPINE)** Capsules 10 mg

Please see PROCARDIA brief summary on adjoining page.

Bactrim™ attacks the (trimethoprim and sulfamethoxazole/Roche) **in acute exacerbations**



Bactrim concentrates in serum
and penetrates sputum¹⁻³



major pathogens of chronic bronchitis*

Bactrim clears sputum of
susceptible bacteria

In sputum cultures from patients with acute exacerbations of chronic bronchitis, *H. influenzae* and *S. pneumoniae* are isolated more often than any other pathogens.^{4,5} One study of transtracheal aspirates from 76 patients with acute exacerbations found that 80% of the isolates were of these two pathogens.⁵

Bactrim is effective *in vitro* against most strains of both *S. pneumoniae* and *H. influenzae*—even ampicillin-resistant strains. And in acute exacerbations of chronic bronchitis involving these two pathogens, sputum cultures taken seven days after a two-week course of therapy showed that Bactrim eradicated these bacteria in 91% (50 of 55) of the patients treated.⁶

involving nearly 700 patients.¹⁰ Overall clinical condition of the patients, changes in sputum purulence, reduction in sputum volume and microbiological clearance of pathogens—all improved more with Bactrim therapy than with tetracyclines. G.I. side effects occurred in only 7% of patients treated with Bactrim compared with 12% of tetracycline-treated patients. (See Adverse Reactions in summary of product information on next page.)

Bactrim is contraindicated in pregnancy at term and nursing mothers, infants under two months of age, documented megaloblastic anemia due to folate deficiency and hypersensitivity.

Bactrim DS. For acute exacerbations of chronic bronchitis in adults* when it offers an advantage over single-agent antibacterials.

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Bactrim reduces coughing
and sputum production

In three double-blind comparisons with ampicillin *q.i.d.*, Bactrim DS proved equally effective on all clinical parameters.^{7,9} Bactrim reduced the frequency and severity of coughing, reduced the amount of sputum produced and cleared the sputum of purulence.

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Bactrim also proved more effective than tetracyclines in 10 clinical trials

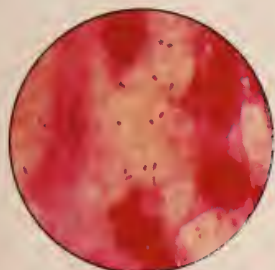
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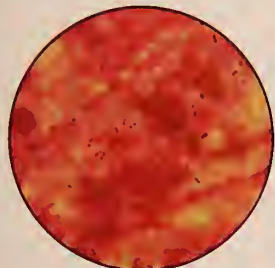
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*Due to susceptible organisms. Please see next page for summary of product information.

attacks *H. influenzae*—even
ampicillin-resistant strains



attacks *S. pneumoniae*





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ORIGINAL PAPERS

Intra-Abdominal Gas Gangrene Occurring During Cancer Chemotherapy

L. H. BRANDON, M.D.
Starkville, Mississippi

THE FOLLOWING case report describes a patient with adenocarcinoma of the gallbladder and/or bile ducts who developed rapidly fatal gas gangrene intra-abdominally during the course of chemotherapy following his surgery. It is particularly interesting because the development of gas gangrene during chemotherapy for gastrointestinal cancer, while not unheard of, is certainly extremely rare. Furthermore, the finding of gas in the biliary tracts, as well as subdiaphragmatically, assisted in the early recognition of the diagnosis.

Case Report

The patient was a 64-year-old white male who appeared on April 20, 1980, complaining of frequent urination, backache, nausea, vomiting, gold colored urine, and mild abdominal pain. Symptoms had begun approximately three weeks earlier, and dark urine had been present for about one week. He had not suffered serious illness or significant gastrointestinal complaint previously.

Physical examination revealed a large, right inguinal hernia, very severe greenish-yellow jaundice, marked enlargement of a hard, nonpainful liver four finger-breadths below the right costal margin.

He gave a history of hepatitis several years earlier.

Dr. Brandon is engaged in the private practice of family medicine in Starkville, MS.

This case report describes a patient with adenocarcinoma of the gallbladder and/or bile ducts who developed rapidly fatal gas gangrene intra-abdominally during the course of chemotherapy following his surgery. The author observes that it is particularly interesting because the development of gas gangrene during chemotherapy for gastrointestinal cancer, while not unheard of, is certainly extremely rare. He reports that the finding of gas in the biliary tracts, as well as subdiaphragmatically, assisted in the early recognition of the diagnosis.

There was no history of excessive alcohol ingestion, gallbladder disease, stomach ulcers, chronic indigestion, or other significant symptoms.

Laboratory data included the following: complete blood count — normal; urine — positive for bile; total bilirubin — 6.5; direct bilirubin — 5.0; indirect bilirubin — 1.5; alkaline phosphatase — 421; SGPT — 78; SGOT — 39; LDH — 141. Hepatitis B surface antigens were negative. Liver-spleen scan indicated dilatation of the hepatic biliary radicles. CT scan of the abdomen showed many dilated ducts in the liver and multiple calcified stones in the gall-

GAS GANGRENE/Brandon

bladder as well as common duct. There were two cysts noted in the right kidney.

The patient was referred to the University of Mississippi Medical Center, where an exploratory laparotomy on April 11, 1980 revealed cholelithiasis and adenocarcinoma of the common bile duct. Cholecystectomy and *roux-en-y choledochenterostomy* was performed. Post-operative chemotherapy consisted of 5-FU and Mitomycin-C. The patient received his third course of therapy between July 22 and July 27, 1980.

The patient reappeared on August 3, 1980, complaining of severe weakness and vomiting. He had experienced shaking chills, fever, anorexia, and profuse sweating. Although acutely ill, he was alert and cooperative. Temperature was 103°F, skin was hot and dry but not jaundiced. No evidence of acute infection could be found in the upper respiratory tract or lungs. Sinus tachycardia with occasional skipped beat was noted. The liver was not palpable. The abdominal scar was well-healed. There was no evidence of ascites or intra-abdominal mass. Admission laboratory data was essentially within normal limits. Three separate aerobic and anaerobic blood cultures were obtained. Initial treatment was then instituted.

On the day after admission, the patient's condition had deteriorated seriously. He had marked abdominal distention revealing a tympanitic percussion note. He had become extremely jaundiced and

was sweating profusely with temperature of 103°F. Preliminary bacteriology report indicated an actively growing gas-producing organism. One tube had the top blown off as a result of the generated gas pressure. Gram stain revealed Gram positive bacilli subsequently identified as *Clostridium Perfringens*. X-rays of the abdomen showed very large collections of free gas under both diaphragms, as well as air in the biliary radicles. Intensive supportive therapy was to no avail.

The patient's condition deteriorated rapidly, and he expired on August 5, 1980.

Summary

This patient undergoing chemotherapy for carcinoma of the bile ducts developed an overwhelmingly severe septicemia with *Clostridium Perfringens*, which was rapidly fatal. The most significant clues as to the etiology of his illness were his precipitous deterioration with high fever, rapidly developing jaundice, and massive abdominal distention due to free air under the diaphragms. The marked abdominal distention was readily apparent on physical examination, and its location under the diaphragms and in the biliary radicles strongly suggested a gas gangrene-type infection. The early and rapid growth of a gas producing organism in the laboratory led to the proper diagnosis. However, as is expected in such a case, the outcome was unaffected by treatment and the patient died. ★★

P.O. Box 1407 (39759)

Otitis Media in Infancy: Observations of a Practicing Pediatrician

JOHN DIXON COFFEY, JR., M.D.

Natchez, Mississippi

THE HIGHEST RATE occurrence of otitis media is in the first two years of life.^{1, 2} It is very frequently undetected in both the acute and chronic exudative phase (otitis media with effusion) mainly because of the failure of physicians to clear debris from the ear canals and to use a pneumatic otoscope. If not detected and treated adequately, effusion may persist for weeks or months, this occurring during the speech forming years. Whether this average of 20 d.B. conduction loss from middle ear fluid later affects cognitive, linguistic, and emotional development is questioned by Paradise,³ who reviews the evidence and advocates "relative conservatism" in the management of otitis media with effusion. A later report by Freil-Patti⁴ and other members of her staff of audiologists, tabulates 71.5% language delay in a group of 14 otitis-prone infants, as compared to 21.4% in a normal controlled group. Bluestone, in the summary of his review on chronic otitis media with effusion, states that attendant conductive hearing loss may be related to abnormalities in cognition, language, and learning; also that since the prevalence and incidence of otitis media decreases with advancing age, palliative management options would appear to be appropriate at present, reserving the more aggressive options for the infants and children who have frequently recurring or chronic disease or the complications or sequelae of otitis media with effusion.

Although I have no controlled studies, it is my impression that persistent otitis media with effusion with acute exacerbations interferes with speech development, especially with vowel sounds, and by causing autophony and discomfort, disrupts the child's feeling of well-being. Furthermore, the parents also are affected by the child's inattention and apparent lack of response to normal conversation, and on occasions, anorexia.

Impedance audiometry has been described as a supplement to physical examination,⁶ but this tech-

The incidence of otitis media in 501 infants followed throughout the first two years of life in the author's private practice is tabulated. He reports that 66% had at least one bout of otitis media, proven by tympanocentesis, and that 29.5% had recurrent otitis media (three or more bouts). He notes the frequency of ampicillin resistant Hemophilus influenzae, describes method of management, and reports an anecdotal case. A discussion of the pathogenicity of Branhamella catarrhalis is included.

nique may give normal tympanograms in infants less than seven months of age who have effusions, this being due to the increased compliance of the ear canals in this age group.

Methods and Results

Clinic records of 501 infants seen in this private practice were reviewed. The infants were born in the period from June 1, 1963, to June 1, 1973. These infants were closely followed for the first two years of life, being seen for well-baby visits as well as illnesses. Of this number, 330 (66%) had at least one bout of otitis media, proven by the demonstration of fluid in the collecting bottle of a Senturia or Alden-Senturia* ear specimen collector after tympanocentesis. This figure means that the incidence was at least 66%, but was probably somewhat higher because some infants may not have been brought in for simple respiratory infections, or the disease may have resolved spontaneously between the less frequent well-baby visits during the second year of life. Of these 330 infants, 43% had at least three bouts of exudative otitis media, this number being 29.5% of the total 501 infants followed.

Cultures were made of all the exudates obtained. *Streptococcus pneumoniae* was the most frequently encountered organism, this being found in 51 cases.

Dr. Coffey is engaged in the private practice of pediatrics in Natchez, MS.

The second most frequent was *Hemophilus influenza*, in 33 cases, followed by *Branhamella* (*Neisseria*) *catarrhalis* in 18 cases. Ears showing bullous myringitis invariably showed effusions in the tympanic cavity on tympanocentesis and showed the same pattern of bacterial growth as otitis media without vesicles or bullae on the tympanic membrane.

During 1977, 126 cultures of *H. influenzae* from tympanocentesis were sent to the microbiology control department of Bristol Laboratories for minimal inhibitory concentrations (MIC) for ampicillin and amoxicillin. Fifteen percent were resistant to the agents (MIC's 8 mcg/ml to 65 mcg/ml with a mean MIC of 20.5 mcg/ml). Twenty-four consecutive cultures had paired MIC's and beta lactamase test.⁷ These included four beta lactamase positive cultures, 20 beta lactamase negative, the test correlating with the MIC tests done at Bristol Laboratories. For the past three years we have been using the simplified Beta Lactamase Reagent Disc.[†] The incidence of beta lactamase positive *H. influenzae* has been approximately 18% using this method.

Discussion

The author's epidemiological data closely agree with Howie's,⁸ who observed 488 infants from birth, and found that 61% had their first attack in the first two years of life. Kaplan⁹ followed 486 Alaskan Eskimos for ten years, finding that 59% had their first attack in the first two years of life.

The author,¹⁰ in 1967, reported the isolation of *Neisseria catarrhalis* in 8% of 698 cultures taken by tympanic paracentesis in infants and children with exudative otitis media. In 24% of these, the organism was found in an intracellular state (phagocytosed by polymorphonuclear leukocytes). It was concluded that the findings of the organism in large numbers in a body area which is normally sterile and in which it has evoked an inflammatory response is evidence of its pathogenicity. This has been confirmed by Leinonen et al¹¹ who demonstrated IgG and IgA antibodies in the middle ear fluid and rising antibody titres in the blood in 10 of 19 children who had *Branhamella* (*Neisseria*) *catarrhalis* in the middle ear. They report that in Finland, 20% of *B. catarrhalis* strains from middle ear fluid of patients with otitis media produce Beta-lactamase, but that all strains were sensitive to erythromycin and to trimethoprim-sulfamethoxazole. They also found *B. catarrhalis* to be the third most common pathogen in middle ear fluid.

In this private practice I no longer do tympanocenteses on all infants in whom otitis media with effusion is found, reserving this procedure for infants who are febrile and appear to be toxic, ill, or in pain, and for those who are not responding clinically to therapy. The initial treatment usually consists of amoxicillin in doses of 50 to 60 mg/kg per day, in three divided doses, given for a period of ten to twenty days. An initial follow up visit is made within one or two days of beginning therapy and again in about ten days after the original examination. If there is evidence of improvement, but incomplete resolution of the effusion, therapy is continued for an additional week or ten days and the ears reexamined. If, on pneumatic otoscopy, there is still some evidence of fluid or tympanic membrane retraction, inflation with a Politizer bag is done, and therapy is often changed to trimethoprim-sulfamethoxazole (Septra), the dose being calculated on a basis of 8 mg of the trimethoprim per kg per day in two divided doses at 12 hour intervals for a period of approximately two weeks. Most of the effusions will be resolved after this period of time. If not, and there is no evidence of fullness of the tympanic membranes, Politizer inflation is repeated, and there is an additional period of observation for a week or so. If middle ear fluid persists after this period of time, consideration is given to tympanostomy with aspiration of the fluid and insertion of pressure-equalizing tubes, which, in infants, can usually be accomplished in the clinic by the use of a Morgan¹² myringotomy tube inserter.

Of the 501 infants referred to above, 55 had pressure-equalizing tubes inserted due to persistent exudate or effusion with recurrent acute otitis media. Under the present program of amoxicillin and trimethoprim-sulfamethoxazole, resolution of middle ear disease is quicker and more often complete with the use of these drugs, singly or in combination, as described above, and the indications for tympanostomy tubes have decreased markedly in this private practice.

Bluestone et al,¹³ conducted a double-blind randomized clinical trial comparing cefaclor and amoxicillin for the treatment of acute otitis media with effusion in 110 children, each receiving a 14-day course of amoxicillin or cefaclor following tympanocentesis. They found that cefaclor was at least as effective as amoxicillin in this disease. They also concluded that cefaclor was effective in the cases of acute otitis media with effusion in which ampicillin-resistant organisms had been isolated and that cefaclor is a reasonable choice for the treatment of otitis media with effusion. I have not conducted a con-

trolled series, but it has been my impression that cefaclor is an effective antibiotic in the treatment of acute otitis media with effusion; but I usually reserve the use of this drug for beta-lactamase producing *H. influenzae*, or for patients who are not responding well clinically to amoxicillin, these patients usually having tympanocentesis done if they fail to respond. One infant with acute otitis media with effusion, treated for three days with the full therapeutic doses of oral cefaclor, failed to respond clinically. This infant's bulging tympanic membrane was aspirated with a Senturia ear specimen collector and needle, and the culture yielded *Streptococcus pneumoniae*, this constituting an in vivo antibiotic sensitivity test.

The author¹ noted purulent eye discharge as a complaint in 18 (9.3%) of 193 patients who had positive middle ear cultures. Bodar¹⁴ reported 132 patients seen with purulent conjunctivitis, 96 (73%) concurrently having otitis media. His observation indicates that the syndrome of purulent conjunctivitis with otitis media is largely a disease of infants and young children. *Hemophilus influenzae* was the most frequent organism isolated from the conjunctivae and the nasopharynx of these patients. Middle ear cultures were not done, but Bodar's 73% rate of *H. influenzae* approximates the author's¹ 72% rate of *H. influenzae* from middle ear exudate of 18 patients with purulent eye discharge. Throughout the years, the author has observed that when an infant is brought in with the complaint of a "cold" along with "matted eyes," acute exudative otitis media is a very likely finding.

Peerless and Noiman¹⁵ studied 50 cases of otitis media with effusion, concluding that antihistamines and decongestants may be causative and precipitating factors in otitis media with effusion by interfering with the normal muco-ciliary activity and eustachian tube physiology.

Readers are referred to the review articles on otitis media in infants and children by Paradise¹⁶ and by Bluestone;¹⁷ These are complete and comprehensive

reviews on the subject. Both recommend "relative conservatism" and palliative management, with more aggressive options being reserved for frequently recurring or chronic disease, or the complications or sequelae of otitis media with effusion. ★★

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The Human Enteroviruses

T. J. BROOKS, JR., M.D.,* and B. J. PHILLIPS, Dr.P.H.

Jackson, Mississippi

THE IDENTIFICATION and classification or, in some cases, reclassification of viruses capable of causing disease in the human alimentary tract is not yet complete. At least seventy-one (71) serotypes have been identified, including four newly recognized types not classifiable into the four original groups.

Most viral infections of the gut are asymptomatic. Others range in severity from mild to fatal, and the complications and sequelae they produce are protean in nature and often devastating in their consequences. It is doubtful if any group of infecting agents is for the practicing physician more difficult to diagnose accurately, more frustrating to manage or more nearly impossible of accurate prognosis than the Enteroviruses. Specific virus identification is expensive, difficult and often impossible and only a few laboratories are equipped to make these determinations.

In temperate and colder climates the enteric viruses occur with greatest frequency in the late summer and early fall, as is characteristic of almost all viral and bacterial disease of the gut. In the tropics there is little or no seasonal variation. In temperate climates they cause "late summer febrile illness," with complications that may include nausea, vomiting, diarrhea, exanthems, enanthems, paralysis, encephalitis, pericarditis, myocarditis, conjunctivitis, pneumonia, hepatitis, pleurodynia, aseptic meningitis and death.

Classification

Enteroviruses, together with the Rhinoviruses (or "common cold viruses") are the major human pathogens of a large family known as the Picornaviridae from *Pico*, meaning small, and *rna* indicating the nucleic acid type. The Enteroviruses have been classified as follows:

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At least seventy-one (71) viruses classified as Enteroviruses are capable of infecting the human gut. Additionally, members of two other families of viruses, the REOVIRIDAE and the CALCIVIRIDAE infect the alimentary tract. Collectively, these infections may be asymptomatic or they may result in a bewildering spectrum of clinical illnesses that defy accurate diagnosis but may lead to serious sequelae including conjunctivitis, diarrhea, pneumonitis, pericarditis, myocarditis, encephalitis, aseptic meningitis, paralysis and death. No specific treatment is available for any of them and only for one group, the polioviruses, are there effective preventive measures.

Family: Picornaviridae

Enterovirus

Polioviruses 1, 2, 3

Coxsackie viruses A (23 types) A-1 to A-24 except for A-23 which has been reclassified, Echovirus-9

Coxsackie viruses B (6 types)

ECHO viruses (32 types) 1-9; 11-27; 29-34

Four newly recognized types are not included in the above. They have been numbered serially 68 through 71.

But the Enteroviruses are by no means the only viruses causing gastroenteritis in man and animals. The family Reoviridae contains the following genera:

Family: Reoviridae

Reovirus

Orbivirus

Rotavirus

Phytoreovirus

Fijivirus

ENTEROVIRUSES/ Brooks

Of the above, the genus Rotavirus is the major cause of Non-Bacterial Infantile Diarrhea. It is so widespread that more than 90% of the population of the United States past the age of 2 years has antibody to human Rotavirus(es).

Rotaviruses are spread by the fecal-oral route. The incubation period is short (1-3 days). They produce fever, vomiting and severe diarrhea with dehydration and electrolyte imbalance. Gastroenteritis due to Rotavirus is a major cause of infant death in countries where malnutrition is prevalent. It is now recognized as a major human pathogen.

At least one other family of viruses causes gastroenteritis in humans. This is the Family Calciviridae, containing the following viruses:

- Family: Calciviridae
- Norwalk virus
- Hawaii virus
- Montgomery County virus (related to Norwalk virus)
- Ditchling virus

Of the four listed, the Norwalk agents have been studied most. They produce epidemic diarrhea in all age groups, characterized by explosive onset with fever, nausea, abdominal cramps, vomiting, anorexia, headache or any combination of these. The disease is usually self-limiting after 24-48 hours.

Clinical Characteristics of Enterovirus Infections

Most Enterovirus infections are asymptomatic, but as a group they are capable of producing an extremely wide variety of symptoms and signs, generally associated with febrile illness of the late summer and fall. In addition, there is much overlapping in the ability of various serotypes to produce clinical manifestations similar to those caused by other types. The more common findings are malaise, fever and diarrhea, or a combination of these. Whether there are other, possibly more serious, complications depends on the specific virus involved, host resistance, age of the patient, etc. The principal characteristics of the various groups are as follows:

Poliomyelitis Viruses

1. Asymptomatic
2. Abortive
3. Major illness
 - A. Non-Paralytic
 - B. Paralytic

Coxsackie Viruses A

Various types of Coxsackie A viruses have been shown to cause

- Asymptomatic infection
- Late summer febrile illness
- Aseptic meningitis
- Paralysis (rarely)
- Rash
- Pneumonitis, pneumonia
- Hepatitis
- *Herpangina

Coxsackie Viruses B

Coxsackie B Viruses have been isolated from persons with

- No symptomatology
- Late summer febrile illness
- *Myocarditis of the newborn and of adults
- Pericarditis
- Rash
- Pneumonia
- Hepatitis
- Encephalitis
- Asceptic meningitis
- Paralysis (rarely)
- *Pleurodynia
- Orchitis
- Conjunctivitis

ECHO Viruses

Echoviruses may cause the following:

- Asymptomatic infection
- Late summer febrile illness
- *Aseptic meningitis
- Encephalitis
- Gastroenteritis
- Rhinitis
- Pharyngitis
- Pleurodynia
- Herpangina
- Pericarditis

It can be seen from the above list that there is much overlapping of clinical syndromes, with the result that specific diagnosis is seldom possible on the basis of clinical findings. Nevertheless, certain features are more likely to be encountered with particular groups and these may suggest the likelihood of specific virus infections.

For example, if paralytic disease appears there is a high probability that a polio virus is present. Although the first Coxsackie isolations were made in 1948¹ from children with paralytic disease in the

* Indicates the clinical syndrome most characteristic of each group.

town of Coxsackie, New York, paralysis is thought to be a rare complication of infection with these viruses.

The classical lesion of Coxsackie A infections is herpangina, an enanthem which appears on the soft palate, pillars of the fauces and tonsils of susceptible persons. The number of lesions is small, usually not exceeding 6 to 8. They are accompanied by sore throat and usually by low grade fever. Additionally, aseptic meningitis is a frequent complication of Coxsackie A infections.

The Coxsackie B viruses are associated principally with epidemic myalgia (Bornholm's disease) and with cardiac myopathies. The first of these is characterized by severe, at times excruciating, pain over the anterior rib cage and upper abdomen. It is paroxysmal in nature and is aggravated by any movement on the part of the patient, or by external stimuli. It is most often seen in children and young adults. Orchitis may be a complication in these age groups.

Of all the Enteroviruses those classified as Coxsackie B are most prone to cause acute myocarditis, especially in the young. Congenitally acquired or neonatal infections are often rapidly fatal. If the patient recovers there is likely to be permanent myocardial damage.

Echoviruses are capable of producing most of the clinical syndromes attributable to the other Enteroviruses, but they are especially prone to cause aseptic meningitis. The findings are those typical of meningeal irritation and include headache, fever, nuchal rigidity and mental confusion. The disease may appear in all respects like non-paralytic polio.

There is evidence that infection with certain of the Enteroviruses may be associated etiologically with other, apparently unrelated diseases. Thus Coxsackie B-2 and B-4 infections have been reported to precede the onset of juvenile diabetes.² Juvenile onset diabetes is usually insulin dependent and may not be genetically determined. This may lend support to the belief that a virus or viruses are of etiologic importance.

Epidemiology

Sporadic cases of poliomyelitis have occurred since very early times, but the disease was not characterized until late in the 19th Century when the first recorded epidemic occurred in Scandinavia in 1891. The virus was first transmitted to monkeys in 1909 by Landsteiner and Popper and eventually it came to be understood that paralytic disease was an uncommon complication of widespread infection whose portal of entry was the alimentary tract. In 1979 the

CDC reported that only 0.1 to 1.0% of persons with poliovirus in their stools developed paralysis,³ but it is not stated whether these are wild viruses or vaccine viruses. Enteroviruses in the stools of infected persons may survive for long periods of time in sewage.

The polioviruses are world-wide in distribution and, in nature, apparently infect only man. Their transmission is by the fecal-oral route, so that in countries where sanitation is poor virtually the entire population is infected at a very early age. When infection is acquired in the first year or two of life paralysis seldom results and epidemics do not occur because the population is basically immune. As sanitary conditions improve and more and more persons are protected from infection early in life epidemics begin to occur and paralytic disease is more common.

The Coxsackie viruses are pathogenic for suckling mice and hamsters. Classification as type A or type B is based on the pathology produced in the mouse. They can be grown in a variety of cell cultures. These include monkey kidney tissue culture and cultures of certain human cell lines. Transmission is also by the fecal-oral route and their epidemiological features are similar to those of polio.

Echoviruses are not pathogenic for any laboratory animal and their existence was unknown until the advent of tissue culture. Like the other Enteroviruses they are transmitted by the fecal-oral route.

Of the four recently discovered Enteroviruses, type 70 appears to be the most important. It has been associated chiefly with explosive outbreaks of acute hemorrhagic conjunctivitis, characterized by acute onset with pain, lacrimation, photophobia and hemorrhage. The disease was first recognized in Africa in 1969, but has since been seen in South East Asia, India and, quite recently, in the United States. It was first reported in the Western Hemisphere in September, 1981 when "thousands of cases were reported in Colombia, Guyana, Surinam and Honduras." An additional 1,200 were reported in Belize and 228 in Trinidad.⁴ Three months later it appeared in American Samoa and by January 4, 1982, 1,034 cases had been reported there.

The first significant outbreaks in the continental United States appeared in Florida in the Miami area and in Key West, beginning on September 4, 1981.⁵ By October 9 "more than 3,500 cases" had been reported to the Dade County Health Department, in Miami, and by September 25 it had been carried to North Carolina by migrant Haitian workers.⁶

In addition to the clinical syndromes already de-

ENTEROVIRUSES / Brooks

scribed, various Coxsackie and echoviruses have been shown to cause upper respiratory disease ranging from the common cold to pneumonia.

The roles of the Reoviridae and the Calciviridae in the etiology of gastroenteritides have been mentioned above. The Rotaviruses, belonging to the Reoviridae are especially important in producing severe diarrhea in the newborn and in very young children.⁷

Diagnosis

The diagnosis of Enterovirus infection must nearly always be made by exclusion of other agents rather than by specific laboratory testing. The reason for this is the lack of laboratory resources at the local level and a lack of simple and reliable tests available for Enterovirus identification. The Centers for Disease Control *does* provide *isolation* of Enteroviruses from clinical specimens but the specimens must be collected within 72 hours of first symptoms, frozen immediately, and kept on dry ice until they are received at the virology laboratory at CDC. Shipment of all specimens must be coordinated through the State Health Department. Results of tests on such specimens require an indefinite, sometimes extended, period of time and an enterovirus isolated from stool or pharynx may not necessarily be the causative agent of the patient's disease.

CDC does *not* provide enterovirus *serology* even if one of the viruses has been isolated from the patient. False negative serologies are a significant problem and, consequently, the value of the test is in question.

Treatment

The treatment of Enterovirus infections is basically supportive. Mild infections may require no therapy. In patients with severe illness the medical management is determined by the symptoms and signs that are present. For example, patients with encephalitis should be protected from central nervous system stimuli such as noise, bright light, and unnecessary movement. Salicylates and possibly narcotics may be indicated for fever and relief of pain. Antidiarrheal preparations will be necessary in many cases. There is no specific treatment.

Prevention

The spectacular decrease in paralytic poliomyelitis in the last two decades has been due primarily to

the availability of the poliovaccines. They are essentially of two types: the formalin killed, sometimes referred to as IVP (Inactivated Polio Vaccine), and the live triple oral poliovaccine (TOPV). The killed vaccine is a mixture of all three types of polioviruses treated with formalin to destroy its infectivity, and administered to children parenterally in a series of four injections plus a booster dose at five year intervals until adulthood is reached.

Oral poliovaccines contain live, virulent virus particles of all three types that have been grown from strains that, through mutation, have lost their neurotropic properties. Modern techniques of manufacture can provide assurances that, when properly stored and administered, the vaccines are stable, safe and effective. In susceptible persons they produce primary infection in the gut in the same manner as wild viruses, resulting in both intestinal and humoral antibody formation, but without neurological complications.

When these vaccine strains are subsequently released into the environment, however, chiefly in the sewage of vaccinated persons, and are passed through other, susceptible, individuals, a small percentage of virus particles may mutate back to the neurotropic strains.⁸ It is chiefly for this reason that entire community populations should be immunized at one time, thus eliminating as many residual susceptibles as possible. Hence, the "Sabin Oral Sundays" of past years when attempts were made to immunize all children in a community up to and including high school ages on the same day.

It has been shown in England and Wales⁹ that vaccine strains of poliomyelitis have become established in the community and that, though they are less likely to cause neurological disease than the original wild strains, continued vigilance is essential.

Intestinal immunity does not result from the administration of killed vaccine, and failure to achieve protective antibody levels has sometimes resulted from both killed and live vaccines. But the poliovaccines are among the safest of all vaccines for human use, causing less than one case of poliomyelitis per 11.5 million persons vaccinated with live virus.¹⁰

For an in-depth discussion of the poliovaccines the reader is referred to the excellent review by Melnick.¹⁰

Vaccines are not available for Coxsackie or ECHO viruses. With only three types of polioviruses it has been possible to produce a vaccine effective against all three. But with at least 68 types of Coxsackie and echoviruses the problem of vaccine production is multiplied many fold. Furthermore, since

all the Enteroviruses are widely distributed in the environment, it is impossible to protect the entire population by sanitary means. These viruses are not killed by ordinary sewage treatment. Contact with cases should be avoided insofar as possible, but truly effective control measures are not now available.

★★★

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Acknowledgment

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Radiological Seminar CCXXVII: Computerized Intravenous Angiography — A First Month's Experience

THOMAS S. MOORE, M.D.,* R. BRENT HARRISON, M.D.,* and GARY D. HARTWELL, M.S.†

DIGITAL INTRAVENOUS ANGIOGRAPHY is a recently-developed technique employing computer processing of radiographic images to generate arteriograms through intravenous injections.^{1, 2} The process basically involves: injection of an iodinated contrast medium into a peripheral or central vein with simultaneous fluoroscopy over the area of interest; digitization and temporary storage in the computer of images obtained before and after the diluted contrast bolus arrives in the arterial phase; point-by-point subtraction of pre-contrast from post-contrast images, removing all background image elements (such as bone or soft tissue); electronic enhancement of the faint arterial images and production of film "hard copies" for viewing. This approach eliminates those risks of conventional arteriography associated with arterial catheterization, such as vessel thrombosis or dissection, making it suitable for screening examinations or high-risk patients.

When it became apparent that this computerized approach to angiography was a very promising technique, we decided to assemble a digital radiographic unit in the Department of Radiology at the University of Mississippi Medical Center from components, rather than purchase a commercially-packaged system. One reason for this decision was our impression that most commercial systems being advertised were still under development, making us uncertain what the final products would actually be. In addition, we felt that some non-medical digital image processors possessed greater capability and flexibility than units incorporated in most commercial digital radiographic systems. We concluded that development of

an in-house system would be a more economical approach, since this would permit us to upgrade individual components of the system as technology advanced rather than replace an entire system. Finally, we felt in-house development would afford the staff and resident radiologists and technologists a better understanding of digital radiography than the purchase of a pre-packaged system.

The digital radiographic system developed at the University of Mississippi Medical Center consists of a Comtal Vision One/10 image processor, a high-resolution Sierra television camera, a Cipher digital tape recorder, a Med Corp multi-format imager, an existing Thomson CSF image intensifier and an existing General Electric radiographic generator. In early 1982 this system became operational, first for trials using radiographic phantoms and then for selected patients. Initially, intravenous digitized angiograms were obtained on patients who were already receiving intravenous contrast medium injections for urography. Occasional patients were accepted for evaluation of clinical vascular problems during spring 1982.

While this system is still undergoing development in terms of improvement in computer software, planned addition of a digital disk drive and a possible television camera upgrade, the images were deemed of sufficient quality by June 1982 that the unit could be used as a clinical tool. Between July 7 and August 6, sixteen clinical examinations were performed. Thirteen studies were classified excellent or good in diagnostic quality and three were considered partial or complete failures. Two failures were caused by misregistration subtraction artifact due to patient motion and one was caused by poor cardiac output which diluted the contrast medium bolus to such a degree that the vessels were not adequately opacified.

Sponsored by the Mississippi Radiological Society.

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Of the 13 diagnostically adequate studies, six were normal (see Figure 1) and seven were abnormal. The normals included visualization of the carotid arteries, renal arteries, aortic bifurcation and iliac arteries. The abnormal examinations revealed a calcified internal carotid artery plaque (see Figure 2), a complete internal carotid artery obstruction, a non-ulcerated internal carotid artery plaque (see Figure 3), a small renal artery (see Figure 4), a giant intracranial carotid aneurysm (see Figure 5), a vertebral artery arteriovenous malformation (see Figure 6) and an external carotid artery stenosis.



Figure 1. Normal carotid artery bifurcations. Note artifacts due to swallowing (curved arrow).



Figure 2. Irregular calcified plaque (arrow) proximal internal carotid artery.

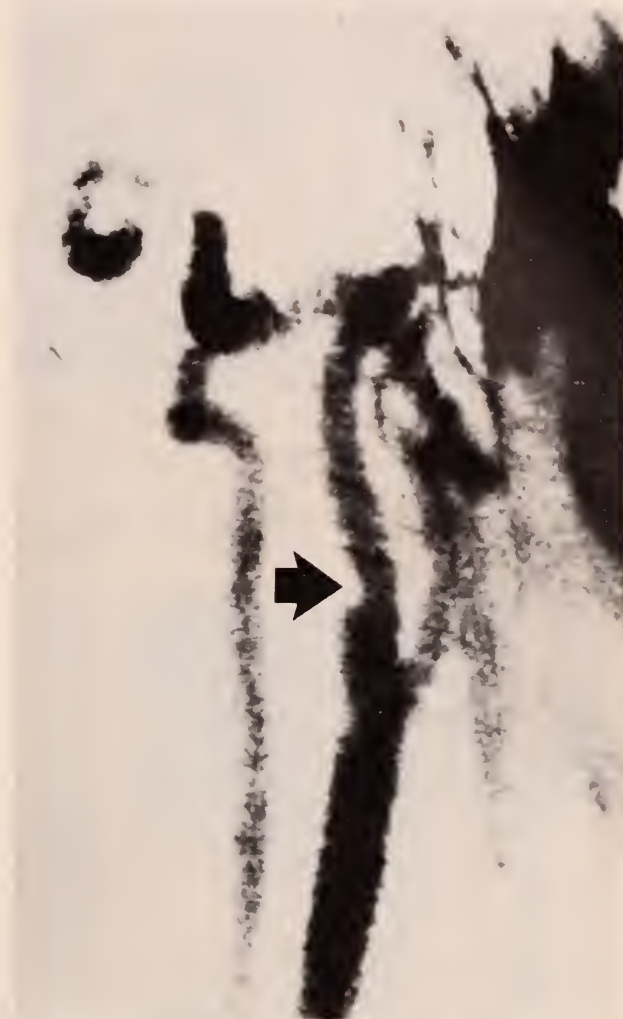


Figure 3. Shallow atheromatous plaque (arrow) proximal internal carotid artery.



Figure 4. Small renal artery (black arrow) in hypertensive patient. Note catheter in inferior vena cava (open arrow).



Figure 5. Giant aneurysm of intracranial internal carotid artery, frontal projection.



Figure 7. Intracranial venous sinuses, occiput, lateral projection.



Figure 6. Vertebral artery arteriovenous malformation (arrow).

Successful studies were performed in patients ranging in age from 10 years to 76 years. One attempted renal artery study in a seven-day-old infant with hypertension failed because of respiratory movement producing misregistration artifacts. Roughly the same number of inpatients and outpatients were examined. Approximately half the injections were performed by rapid hand injection of contrast through a short intravenous cannula in an antecubital vein, while the remainder were performed with a mechanical injector through a pigtail catheter placed either in the superior or inferior vena cava.

Each injection consisted of 40 ml of 76 percent meglumine-sodium diatrizoate (Renografin-76, Squibb), injected at 10 ml/sec in peripheral veins and 20 ml/sec in central sites. In apprehensive patients and children, intravenous diazepam provided satisfactory sedation and for abdominal studies intravenous glucagon and abdominal compression bands were generally employed to diminish peristaltic and respiratory motion artifacts.

Based on this initial experience, we have reached a number of conclusions, but several questions remain unanswered. Digital intravenous angiography is an excellent screening technique and in many cases will provide sufficient diagnostic information that conventional arteriography can be omitted. The cervical carotid arteries can be adequately visualized with a hand injection in an antecubital vein if these veins are of adequate size. A mechanical injection through a pigtail catheter in the superior or inferior vena cava appears preferable if intracranial, intrathoracic or intraabdominal vessels are to be demonstrated. Hand injections in peripheral veins result in a quicker and less invasive examination than central injections; the complete procedure involving hand injections will generally last about 45 minutes while procedures involving central injections take approximately 90 minutes. The times required for these procedures are decreasing as experience is gained and routines are developed.

Renal artery examinations have been particularly prone to respiratory and peristaltic motion artifacts while swallowing and movement artifacts in carotid artery studies have been relatively less troublesome.

While we have only limited experience with intracranial studies, a central catheter injection will likely be of advantage in demonstrating intracranial arteries and venous sinuses (see Figure 7). We do not yet have the computer software to reregister mask and contrast images to correct motion artifacts and therefore we cannot comment on the value of this feature. We feel the addition of a magnetic disk drive will be a significant improvement in allowing a more rapid collection and storage of images.

In addition to intravenous angiography, we feel digital subtraction image processing will begin to play a major role in conventional arteriography as well, since it can provide real-time enhancement and subtraction from arterial injections of much smaller volumes of contrast than those required for conventional arteriography. Pulmonary angiography is one area in which we anticipate significant benefits from digital image processing techniques. While the in-

travenous approach can be employed, direct injections through indwelling Swan-Ganz pulmonary artery catheters should permit high quality pulmonary angiograms with contrast medium volumes much smaller than those required for conventional pulmonary angiography.³ We plan to begin trials of digital subtraction pulmonary angiography in the near future. ★★★

2500 North State Street (39216)

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The President Speaking

You Are Cordially Invited . . .

SIDNEY O. GRAVES, JR., M.D.
Natchez, Mississippi

The reason for this page this month is very simple. I want to invite you to the 115th Annual Session of your Mississippi State Medical Association. On the surface, you may think this is a rather ridiculous reason for writing an article, but before you turn to the next page, read a little further.

There are over 2,000 members of this association at the present time, and this is an increase of almost 50 percent in the last ten years. In spite of this, attendance by the members of the association and the auxiliary, at an average meeting, rarely exceeds 500. That means that 75%-plus of you do not attend our annual meeting. I know there are lots of reasons for your not attending — I could list twenty or more valid excuses — but the bottom line is that you should attend to find out what is happening in Mississippi Medicine.

I know that there are always several in each component society who “like to go to *the* meeting” and *you* know they are going “to look after your interests.” But do they? Have you ever been there to see for sure?

At the meeting scheduled for mid-May at the Royal d’Iberville in Biloxi, there will be many proposed changes in our organization. These will need much thought and discussion. I will mention a few.

The nominating process has been completely reorganized. For the first time, the nominees for office are being published sixty days prior to the meeting. There have been some flaws in this new process which need attention.

At least two plans are being proposed for the reorganization of the Mississippi State Medical Association. One proposition would drastically realign the Districts. The other plan would completely abolish Districts. I would think that all of you would be interested in discussing this problem.

Another subject that is not well appreciated, but is certainly looming on the horizon, is the many changes in the hospital organization. I look for extended discussion on this problem at the meeting.

There are recommendations to change the Council and Committee structures with some of these groups to be completely deleted.

Plans are complete for extensive changes in the Scientific Program Format.

On a less controversial level we have Mark Russell, who will entertain at the annual party. He is perhaps the best entertainer that we have been able to engage to date.

This is but a brief glimpse of the type of action scheduled for May 11-15. We are holding the meeting for the first time on a Wednesday through Sunday basis in hopes of much better attendance.

Help us prove that we are right in choosing a time of the week when more people would be able to attend. Make your reservation at once and come to Biloxi in May.

★★★

EDITORIALS

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Emphasis on Action

It will soon be ten years since I had the privilege of serving as state president, and sitting here now searching for a topic on which to base an editorial I realize that the same problems for us that were belabored then are still with us.

Futility, I guess, is what is depressing me. How to get the rank and file membership interested in the political doings that affect our practices.

We — some of us at least — scan the "Blue Sheet" every week and dutifully make the "phone calls" asked of us, wondering, doubting, whether any of our efforts have the least effect on anything passed or defeated down there. The chasm between the private practice of medicine and the verbose paper-laden machinations of our duly elected representatives still exists.

In spite of Bucky's repeated reminders that we, the profession, could exercise some real clout if we would only buckle down and get the job done, we nearly all are perfectly willing to let him carry our burden almost alone. After all, he is young, competent, and is in his element down there at the legislature, so we feel that we can sit back, relax, and wait on forthcoming votes in our favor.

No longer are we a breed apart and above the tortured ramifications of the political mind. We must face this fact and lend our total support. We must, absolutely must, get (God! This word again) *involved*!

ARTHUR A. DERRICK, JR., M.D.
Associate Editor

Medico-Legal Brief

Wrongful Birth Verdict Not Inadequate

As an offset to an award to a mother for "wrongful birth," a jury was under a duty to take into account the special benefits inherent in the parent-child relationship, a California appellate court ruled.

The mother consulted a gynecologist with regard to a bilateral tubal ligation. After the operation, a pathology report stated that a specimen submitted as a section of the left fallopian tube could not be identified as such.

The mother became pregnant about a year and a half later. The physician who examined her, a nephew of the gynecologist, offered to perform an abortion free of charge, arrange for adoption of the expected child, or perform another tubal ligation without charge. The mother decided to keep the child.

The mother sued the gynecologist, charging negligence in performance of the tubal ligation. There was a conflict in the expert testimony as to whether or not a surgeon performing a tubal ligation had a duty to ascertain the results of the postoperative pathologic examination and inform the patient. The gynecologist did not recall seeing the mother's report until after her pregnancy was confirmed, although the second physician found it in her file when he examined her. The jury decided for the mother and awarded her \$1,708 in damages.

On appeal, the mother contended that the damages awarded were inadequate. She contended that the value of probable expenses for raising her child to age 18 was approximately \$80,000, that her lost earnings were approximately \$5,500, and the value of a college education for the child was approximately \$10,000. She also contended that the trial court erred in permitting testimony as to her refusal to obtain an abortion or place her child for adoption to be received in evidence to establish a failure on her part to mitigate damages.

The appellate court said that although the latter evidence was objectionable on the issue of mitigation of damages, the mother could not assert it as a ground for reversal where it was first introduced on direct examination of the mother. She admitted that her child was beautiful, brought her more pleasure than pain, and had enhanced her relationship with the child's father. The court found that under its instructions, the jury had a duty to take into account the benefits of the parent-child relationship, and that it could not be said as a matter of law that the award was outrageously inadequate or the trial judge erred in upholding it. Finding no abuse of discretion, the court affirmed the lower court's judgment. — *Morris v. Frudenfeld*, 185 Cal.Rptr. 76 (Cal.Ct. of App., Aug. 16, 1982)

MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 19-23, 1983, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

Mississippi State Medical Association, 115th Annual Session, May 11-15, 1983, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, July 6-9, 1983, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39221.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November, H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clark, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Richard C. Carter, Pres. and Secy., 314 W. Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegasus Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Pendergrass, Secy., 201 Hospital Dr., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community/Gulfport
Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Biloxi Regional Medical Center
1559 Lafayette St.
Biloxi, MS 39533

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

South Washington County Hospital
Drawer 398
Hollandale, MS 38748

MEDICAL ORGANIZATION

MSMA Public Information Campaign Wins Award



MSMA's attention-getting television messages focusing on the malpractice crisis in Mississippi can now be called award-winning television messages. The series was named winner of a Gold Award (first place) in the "Excellence in Advertising" awards competition of the Greater Jackson Advertising Club in February. In the photo above, MSMA president Dr. Sidney O. Graves, center, displays the award with MSMA executive director Charles Mathews, left, and Dick Silver, president of Graphic Consultants, public relations firm which produced the commercials.

Preliminary Plans Announced For 115th Annual Session

The 115th Annual Session of the MSMA will get underway May 11 at the Royal d'Iberville Hotel in Biloxi. This marks the first year of the new Wednesday-Sunday meeting schedule which was adopted by the House of Delegates in 1981.

Mark Russell, noted political satirist, will entertain at the annual membership banquet on Friday, May 13. Other evening activities during the five-day session will include the President's Reception on Wednesday, medical alumni reunions on Thursday, and a reception hosted by MMPAC on Saturday.

House of Delegates sessions are set for Thursday, May 12 and Sunday, May 15. Special guest Dr. William Y. Rial, president of the American Medical Association, will address the delegates. Reference committee hearings are set for Thursday afternoon.

The scientific program begins on Friday, May 13, with sessions conducted by the sections on family practice, surgery, medicine, ob-gyn, pediatrics, and preventive medicine. Saturday's schedule includes scientific programs conducted by the sections on EENT, anesthesiology, pathology, radiology, psychiatry, dermatology, urology, and orthopedic surgery. More than 30 lecturers will make presentations during the section meetings and at a number of specialty society meetings which have been scheduled.

The scientific program also includes the Third Annual James Grant Thompson Memorial Lecture, to be delivered this year by Dr. John Beal of Chicago, IL, president of the American College of Surgeons.

The special activities agenda includes the annual golf tournament (Wednesday), tennis tournament (Saturday) and deep-sea fishing rodeo (Friday and Saturday). Scheduling of meetings has been arranged to leave Saturday afternoon open, permitting registrants to enjoy the many activities that the Gulf Coast offers.

115th Annual Session May 11-15, 1983 Preliminary Program

Wednesday, May 11

Golf Tournament
President's Reception

Thursday, May 12

House of Delegates
Reference Committees
Miss. Foundation for Medical Care
Medical Alumni Reunions

Friday, May 13

Section on Family Practice
Section on Surgery/American College of Surgeons
Section on Medicine
Section on Ob-Gyn
Section on Pediatrics
Section on Preventive Medicine
MSMA Banquet (Mark Russell)

Saturday, May 14

Medical Assurance Company of Miss.
Section on EENT
Section on Anesthesiology
Section on Pathology
Section on Psychiatry
Section on Radiology
Section on Urology
Section on Dermatology
Section on Orthopedic Surgery
MSMA Auxiliary General Meeting
Tennis Tournament
MMPAC Campaign Reception

Sunday, May 15

House of Delegates

State's First Marrow Transplant Patient Is Doing Well

Hematologists at the University of Mississippi Medical Center have performed the state's first bone marrow transplant.

Dr. Joe C. Files, assistant professor of medicine (hematology) reported that Matthew Martin, a 20-year-old Choctaw Indian from Conehatta, is doing well three months after the procedure.

Martin had severe aplastic anemia of unknown origin. "Spontaneous remission often occurs if the anemia is not too severe, especially in cases which result from exposure to certain antibiotics," Dr. Files said. "But those with the severe form of the disease never get better."

The one-year survival rate is less than 20 percent, and those who do survive the year are transfusion-dependent, he said. Their white count never arises to the extent that they can fight infections successfully nor does their low platelet count allow for adequate clotting.

Martin was newly diagnosed when he was referred to the Medical Center. "That helped us," Dr. Files said.

But his worsening condition was apparent after the first blood test. His hematocrit was seven; his platelet count was 4000, down from a normal of 250,000. His white count was only 16 percent of what it should have been.

"Normal bone marrow just wasn't there to make all the components of blood which life requires," Dr. Files said.

The likeliest donor was Martin's 23-year-old brother whose tissue type closely matched his brother's.

"The marrow of the donor regenerates completely in about four weeks," Dr. Files explained.

In a two-hour procedure, marrow is taken from the donor's pelvis in small units. The pelvis is rich in marrow and easily accessible. The recipient receives the marrow, just as he would a unit of blood.

"The bone marrow cells 'know' what to do," Dr. Files said, "and they route themselves to their place deep inside the bone and start reproducing themselves in their new host."

On the 16th day following the transplant, Martin's own marrow started functioning. It made its own red cells, white cells and platelets.

At discharge, Martin's hematocrit was up to 30, his platelet count was 175,000 and his white count was within 60 percent of normal.

Dr. Files thinks the UMC patient has a "good chance for a completely normal life." The greatest

risk of the procedure is the possibility of graft-versus-host disease. Martin now takes immunosuppressive drugs to lessen the possibility of the reaction. At the end of three months, if he shows no signs of the disease, he'll be taken off medication. If there are signs that the new marrow is attacking his body, he'll continue the drugs for a year.

The chances of a successful transplant decrease in proportion to the number of blood transfusions the patient had prior to the transplant, Dr. Files said. Martin had been transfused eight times before he came to the Medical Center, but appears to be having no problems with rejection.

"We don't know the exact correlation between the number of transfusions and the chances of graft rejection in humans. We do know that the ideal number of transfusions is zero," Dr. Files said.

Research has shown that animals which were given a unit of blood prior to transplant rejected the graft nine out of ten times. Untransfused animals accepted the graft nine out of ten times.

Patients who've had blood transfusions have already been exposed to foreign antigens, making them more vulnerable to the rejection process, Dr. Files said.

Family Medicine Symposium Scheduled for Next Month

The University of Mississippi Medical Center will sponsor a four-day course for family physicians April 6-9 at the Holiday Inn Medical Center in Jackson.

The program will center on advances in treating problems encountered in daily practice. Special activities will include videotape presentations in registrants' motel rooms, a breakfast session, a wine and cheese social, cocktails and dinner, and a tour of Vicksburg.

Sponsors of the symposium are the School of Medicine Department of Family Medicine, the UMC Division of Continuing Health Professional Education and the Mississippi Academy of Family Physicians. Course coordinators are assistant professors of family medicine Dr. Franklyn Dornfest, Dr. Robert Forbes, and Dr. Robert Willis.

Fee for the course is \$175. Participants may earn 16.1 credit hours in Category I of the Physician's Recognition Award of the American Medical Association, 16.1 hours by the American Academy of Family Physicians, and continuing education credit. An additional hour will be awarded for attendance at the breakfast session.

POSTGRADUATE CALENDAR

March 10-12

POSTGRADUATE SURGICAL FORUM X
Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery and the UMC Division of Continuing Health Professional Education.

Coordinator: Dr. J. Harold Conn, Professor of surgery; and chief, Division of Surgery, Veterans Administration Medical Center.

An outstanding guest faculty will join UMC faculty members in presenting sessions on controversial problems in surgery, endocrine surgery, vascular surgery, surgical oncology, and biliary-pancreatic surgery. Registrants are invited to bring problem cases, along with X-rays, to present for discussion during conferences.

Fee: \$275. Credit: 22 credit hours in Category I of the Physician's Recognition Award of the AMA.

March 17-18

MEDICINE IN THE OLD SOUTH
University Medical Center and Old Capitol, Jackson

Sponsored by the University of Mississippi Center for the Study of Southern Culture and the University of Mississippi Medical Center Division of Continuing Health Professional Education.

Coordinator: Ann Abadie, Associate Director, Center for the Study of Southern Culture, University of Mississippi.

This 1983 Barnard-Millington Symposium will bring together historians of American medicine and of the South as well as scholars in folklore and religious studies to view the state of medicine in the Old South against the backdrop of the rest of the nation. Authors, commentators and scholars from throughout the nation will participate in the eight sessions.

March 24-25

FIFTH ANNUAL NEUROLOGY SPRING SYMPOSIUM
Medical Center Holiday Inn, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Neurology, the Veterans Administration Medical Center

Neurology Service and the UMC Division of Continuing Health Professional Education.

Coordinator: Dr. Shri K. Mishra, associate professor of neurology.

This two-day course will provide an indepth review of selected system disorders affecting the central nervous system, the peripheral nervous system and the muscle. Clinical aspects of various neurological manifestations of systemic disorders will be addressed. Fee: 150. Credit: 13 contact hours AMA Category I.

March 26

PHOTOGRAPHY UPDATE FOR EDUCATION AND SLIDE PROGRAMS
Kessler Air Force Base, Biloxi

Sponsored by the University of Mississippi School of Dentistry, the UMC Division of Continuing Health Professional Education, and Kessler Air Force Base Medical Center.

Coordinator: Dr. William Akerly, Associate Professor of Restorative Dentistry.

Close-up photography will be taught, as well as planning and producing slide presentations for teaching or personal use. Registrants will participate by making and coloring slides for projection. Fee: \$60. Continuing education credit is offered.

FUTURE CALENDAR

April 6-9

FAMILY PRACTICE UPDATE
Holiday Inn Medical Center, Jackson

April 9

MS ULTRASOUND SOCIETY SPRING SONIC SYMPOSIUM
University Medical Center, Jackson

April 16

COLORECTAL CANCER
University Medical Center, Jackson

April 30-May 1

NUCLEAR MEDICINE UPDATE
University Medical Center, Jackson

For more information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone 987-4914.

NEW MEMBERS

EMRICK, FRED G., Natchez. Born Brooklyn, NY, Feb. 9, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and radiology residency, University Medical Center, Jackson, MS, 1976-80; elected by Homochitto Valley Medical Society.

GILDER, DAVID M., Yazoo City. Born Greenville, MS, Feb. 19, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned one year, Huntsville, AL; elected by Delta Medical Society.

MCIVER, WILLIAM B., Natchez. Born Edmonton, Alberta, Canada, April 21, 1944; M.D., University of Alberta Faculty of Medicine, Edmonton, 1968; interned one year, Royal Alexandra Hospital, Edmonton; anesthesiology residency, Royal Alexandra hospital and University Hospital, Edmonton; Shanghanessy Hospital, Vancouver, and Vancouver General Hospital, 1969-73; elected by Homochitto Valley Medical Society.

MILIC, GENE Z., Grenada. Born Belgrade, Yugoslavia, Sept. 22, 1938; M.D., Belgrade Medical School, 1965; interned University Hospital, Belgrade, one year; ob-gyn residency William Beaumont Hospital, Royal Oak, MI, 1971-74; fellowship in endocrinology and infertility, Michael Reese Medical Center, Chicago, 1974-76; elected by North Central Medical Society.

MOAK, JOSEPH S., JR., Brookhaven. Born Brookhaven, MS, Nov. 12, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and internal medicine residency, Baptist Memorial Hospital, Memphis, 1978-82; elected by South Central Medical Society.

NOWELL, GARY H., Jackson. Born Jackson, MS, Jan. 22, 1952; M.D., University of Mississippi School of Medicine, Jackson, March 31, 1979; interned and internal medicine residency, Baptist Memorial Hospital, Memphis, 1979-82; elected by Central Medical Society.

O'MARA, CHARLES S., Jackson. Born Jackson, MS, Sept. 23, 1948; M.D., Tulane University School of Medicine, New Orleans, 1973; interned and general surgery residency, Johns Hopkins Hospital, Balti-

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more, 1973-79; peripherovascular fellowship, Northwestern University Hospital, Chicago, 1979-80; elected by Central Medical Society.

SIMON, CARMEN, Starkville. Born Winnipeg, Canada, Sept. 11, 1939; M.D., University of Puerto Rico School of Medicine, San Juan, 1965; interned one year, University Hospital, Rio Piedras, Puerto Rico; psychiatry residency, St. Elizabeth's Hospital, Washington, DC, 1966-67; psychiatry residency, Temple University Hospital, Philadelphia, PA, 1967-69; elected by Prairie Medical Society.

SLUIS, GORDON W., Vicksburg. Born Martinez, CA, Dec. 30, 1953; M.D., Johns Hopkins University School of Medicine, Baltimore, 1979; interned and pediatric residency, Children's Hospital, Pittsburgh, PA, 1979-82; elected by West Mississippi Medical Society.

SNEED, WILLIAM F., Jackson. Born New Orleans, Dec. 17, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned University of Alabama Affiliated Hospitals, Birmingham, one year; general surgery residency, Ochsner Medical Foundation, New Orleans, 1977-79; otolaryngology residency, Baylor College of Medicine, Houston, TX, 1979-82; elected by Central Medical Society.

STUDDARD, WILLIAM EARL, Jackson. Born Walla Walla, WA, Jan. 4, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned and radiology residency, University Medical Center, Jackson, MS, 1974-78; neuroradiology fellowship, George Washington University, Washington, DC, 1978-80; elected by Central Medical Society.

THOMPSON, FRED E., Jackson. Born Brookhaven, MS, March 1, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned University Medical Center, Jackson, MS, one year; Master of Public Health, Johns Hopkins University School of Hygiene and Public Health, Sept. 1981-May 1982; elected by Central Medical Society.

THORNTON, DANIEL R., III, Meridian. Born Meridian, MS, March 1, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and ob-gyn residency, Truman Medical Center, Kansas City, MO, 1977-81; elected by East Mississippi Medical Society.

WALDEN, JERRY LEE, Ripley. Born Tupelo, MS, Nov. 2, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1981; one year family

practice residency, University of Tennessee, Jackson, TN, 1981-82; elected North Mississippi Medical Society.

WOOD, ARTHUR E., III, Waynesboro. Born Shreveport, LA, Feb. 8, 1954; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned one year, University of Alabama Huntsville; elected by South Mississippi Medical Society.

WOODLIFF, DAN M., Jackson. Born Jackson, MS, Nov. 30, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and medicine residency, University Medical Center, Jackson, MS, 1978-82; elected by Central Medical Society.

PERSONALS

JAMES ACHORD of UMC attended the recent executive committee meeting in New York of the American College of Gastroenterology.

J. M. BROCK of McComb spoke at the meeting of the Academy of Cutaneous Surgery in Chicago.

O. WINSTON CAMERON, JR. has associated with Meridian Orthopedic Clinic for the practice of orthopedic surgery and hand surgery.

WILLIAM A. CAUSEY has associated with Jackson Medical Associates, P.A., for the practice of internal medicine and infectious diseases.

WALLACE CONERLY of UMC spoke at a meeting of the Georgia Society for Respiratory Therapy in Atlanta and was a site visitor at the Medical College of Georgia in Augusta in January.

MILAM S. COTTEN of Hattiesburg spoke on laser techniques and intraocular lens implantation at a seminar in Rome, Italy, and also attended seminars in Paris and London.

KENT A. DARSEY announces the opening of his family medicine practice at 1216 23rd Avenue in Meridian.

VERNON W. DOSTER of Brookhaven announces the association of PAUL HERGENROEDER for the practice of obstetrics and gynecology.

CLAUDE EARL FOX of Jackson recently served as a member of the faculty for a Symposium on Human Genetics presented by Emory University School of Medicine in Atlanta, Georgia.

PERSONALS/Continued

KARL HATTEN of Vicksburg attended the recent meeting of the National Kidney Foundation in Chicago as a delegate, trustee, and state president of the Mississippi Kidney Foundation.

PHIL A. HOOKER announces the opening of his office for the practice of allergy at 320 S. Gloster Street in Tupelo.

WILLIAM LEWIS of Forest has been named a diplomate of the American Board of Family Practice.

ANDREW J. MYRICK announces the opening of his office for the practice of medicine and surgery at 609 Van Buren Avenue in Oxford.

JOE NORMAN of UMC made a presentation at the Tri-State Thoracic Society meeting in Biloxi.

MARCELENE J. O'NEAL of Greenville announces the association of SUSAN NEELLEY O'NEAL in the practice of pediatric medicine.

WILLIAM PINKSTON of UMC made a presentation at the recent Tri-State Thoracic Society meeting in Biloxi.

FRED C. ROBINSON announces the opening of his office for the practice of pediatric medicine at Doctors Park, Highway 8 East, in Houston.

MARCELO RUVINSKY of Jackson was recently elected chief of the medicine section of St. Dominic-Jackson Memorial Hospital's medical staff, and BARRY WHITES of Jackson was elected secretary.

ALBERT W. STEELE has associated with WILLARD H. BOGGAN, DWIGHT S. CADY, MARVIN H. JETER, and GARY H. NOWELL for the practice of internal medicine at Suite 102, 2969 University Drive, in Jackson.

JOHN R. STRIPLING, III of Gulfport has been elected chief of staff at Garden Park Community Hospital. Other newly elected officers are DWIGHT H. SHORT, II, vice-chief, and DAVID E. BYRNE, secretary-treasurer.

MARY WHEATLEY of Jackson was recently elected secretary of the psychiatry section of the medical staff of St. Dominic-Jackson Memorial Hospital, and HARDY WOODBRIDGE of Jackson was elected secretary of the general practice section.

UMC Will Host Neurology Symposium

The University of Mississippi Medical Center will host the fifth annual Neurology Spring Symposium March 24-25 at the Holiday Inn Medical Center in Jackson.

The symposium will focus on neurological manifestations of systemic disorders — primarily cardiac, aging and cancer.

Sponsors are the University of Mississippi School of Medicine Department of Neurology, the Veterans Administration Medical Center Neurology Service and the UMC Neurology Service and the UMC Division of Continuing Health Professional Education. Course coordinator is Dr. Shri K. Mishra, associate professor of neurology and chief, neurology service, Veterans Administration Medical Center.

Joining UMC faculty members as guest faculty are Dr. Herbert R. Karp, professor and chairman, Department of Neurology, Emory University School of Medicine; Dr. William R. Shapiro, professor of neurology, Cornell University School of Medicine, and attending neurologist, Cotzias Laboratory of Neuro-Oncology, Memorial Sloan-Kettering Cancer Center; and Dr. Frank M. Yatsu, professor and chairman, Department of Neurology, University of Texas Health Sciences Center, Houston, Texas.

Course fee is \$150. The program meets criteria for 13.8 contact hours in Category I of the Physician's Recognition Award of the American Medical Association.

For information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone 987-4914.

Faculty Appointment at UMC

Dr. William Burton Lushbaugh joined the University of Mississippi Medical Center faculty as an associate professor of preventive medicine February 21.

Dr. Norman C. Nelson, UMC vice chancellor for health affairs, announced his appointment, following approval by the Board of Trustees, State Institutions of Higher Learning.

Dr. Lushbaugh has been an assistant professor of medicine at Medical University of South Carolina since 1978, and was a microbiologist at the Research Center of the Veterans Administration Medical Center in Charleston, S.C. He earned his Ph.D. at the LSU School of Medicine.

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SOLVING THE MYSTERY OF PASCAGOULA

More than 20 years ago, a combined demonstration of medical science and community effort turned an outbreak of infectious hepatitis in Mississippi into a national landmark of disease prevention.¹

When health officials in Pascagoula, Mississippi, reported more than a dozen cases of hepatitis, the Communicable Disease Center in Atlanta assigned an epidemiologist to aid local efforts in tracing the origin of the infection.

Nurses on duty at the Jackson County Health Clinic and physicians at Singing River Hospital were interviewed, as were the patients themselves. It soon became clear that the patients had not shared a meal, had not frequented the same restaurant and had not been together in any of the most likely sites for contamination. However, a startling fact did come to light... each of the 13 infected patients had eaten raw oysters within the previous two months.

Checking and double-checking the clues...

Raw oysters were a common food in Pascagoula, but at that time shellfish were not known to cause hepatitis. As a control, 13 names were selected from the city's

telephone book. Each person questioned denied having eaten oysters, and none had symptoms of hepatitis. The investigation was narrowing down, but there was still much probing to be done.

...to find the cause

With the assistance of a sanitation engineer and a shellfish expert, the investigators began the tedious task of inspecting the local stores, oyster plants, packagers and shucking companies. Finally, they found the source of the infections: an oyster bed at the mouth of the Pascagoula River, ordered closed to oystering some 30 years earlier because it was polluted.

The diligent work of 20 specialists—epidemiologists, virologists, bacteriologists, internists, pediatricians and public health officers—had led to an awareness of shellfish as potential hepatitis carriers, and to the need for closely regulating both shellfishing and water pollution protections. The work done in Pascagoula stands as a remarkable joint effort in the history of modern medicine in the United States.

Reference: 1. An era of specialists, chap. 5, in Lee RV, Eimerl S *et al.* *The Physician*. New York, Life Science Library, Time Inc., 1967, pp 107-109



When the history reveals anxious depression...

For the estimated 70 percent of nonpsychotic depressed patients who are also anxious,¹ Limbitrol provides both amitriptyline, specific for symptoms of depression, and the effects of Librium® (chlordiazepoxide HCl), the tested and dependable anxiolytic. Limbitrol is, therefore, a better choice for these patients than dual agents that contain a phenothiazine, a class of antipsychotic drugs used infrequently in nonpsychotic patients.¹

62% of Overall Improvement...Within the First Week

Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.²

In another multicenter study,³ the following symptoms associated with anxious depression were significantly reduced during the first two weeks of therapy:

- ☐ Headache—79%
- ☐ Early insomnia—91%
- Middle insomnia—87%
- Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.³

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jarvik ME; New York, Appleton-Century-Crofts, 1977, p. 316. 2. Feighner JP et al: *Psychopharmacology* 61: 217-229, Mar 1979. 3. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

The specific antianxiety/antidepressant

Limbitrol®

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline
(as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline
(as the hydrochloride salt)

Please see summary of product information on following page.

LIMBITROL TABLETS (®) Tranquizer—Antidepressant

Before prescribing, please consult complete product information, a summary at which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias at the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12 5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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PATHOLOGIST-ONCOLOGIST seeks practice location. Frank P. Urso, M.D., P. O. Box 1149, Akron, OH 44301.

FAMILY PRACTICE resident seeks practice location in July 1983. Contact John D. Sites, M.D., 2002 Phil-lip Dr., Muncie, IN 47302.

ANESTHESIOLOGIST seeks to relocate in state in solo, group or institutional practice. Contact M. T. Olivo, Jr., M.D., Box 794, Oxford, MS 38655.

SURGEON seeks location with established group in small city. Currently service as chief surgical resident at Ochsner Foundation Hospital. Available July 1983. Contact Thomas C. Kelly, M.D., 1516 Jefferson Highway, New Orleans, LA 70121.

PEDIATRICIAN seeks practice location in central or Gulf Coast area upon completion of residency in July 1983. Contact Steven D. Eggen, M.D., Alton Ochsner Medical Foundation, 1516 Jefferson Highway, New Orleans, LA 70121.

PATHOLOGIST seeks position in community hospital setting upon completion of residency in June 1983. Contact Robert J. Sinnenberg, M.D., Box 662 MCV Station, Medical College of Virginia, Richmond, VA 23298.

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References: 1. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 4. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 5. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Kales JD: *Pharmacol Physicians* 4:1-6, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5:25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The

sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. **Adults:** 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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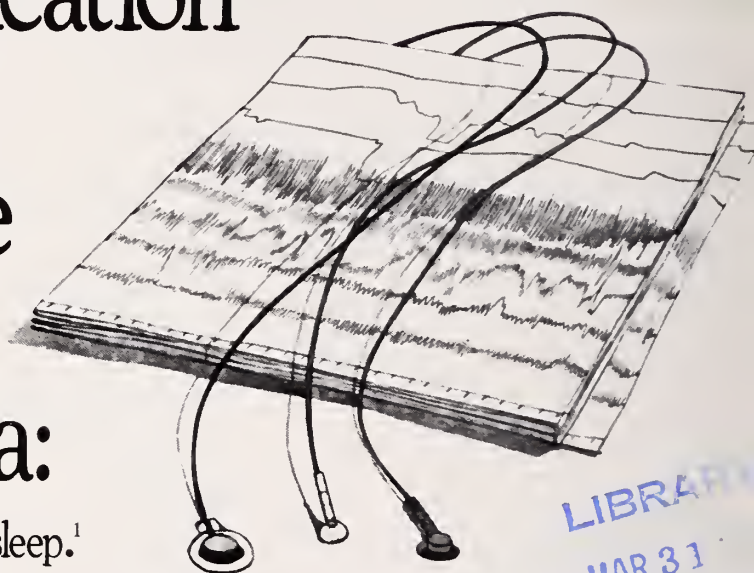
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ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 µg/ml and 0.09 µg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS **PREGNANCY:** VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.

VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
December 1979

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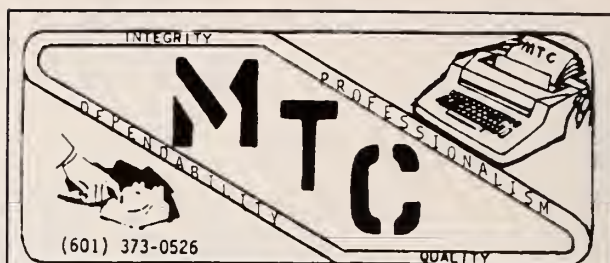
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Low Score in Side-Effect Risk

Through more than 13 years of worldwide use, ibuprofen continues to demonstrate exceptional gastrointestinal tolerance vis-a-vis aspirin and other antiarthritic agents. In a recent series of double-blind trials of ibuprofen, naproxen and other NSAID's, only placebo was shown to produce less G.I. lesions than ibuprofen on gastroscopic examination.⁵



Boots Pharmaceuticals, Inc.
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See next page for brief summary of prescribing information.

Measure RUFEN[®] (ibuprofen) for GI Tolerance Even in arthritic patients with a history of GI disease



And Rufen[®] Measures Up Best

Over a five-year period, ibuprofen was administered to 64 patients with known peptic ulceration and 42 with known gastric intolerance to other antiarthritis drugs.

Twenty-six patients remained in treatment, 23 left treatment following remission, and 35 dropped out for reasons unrelated to side effects. In this specially selected group of GI-intolerant patients, only 13 (12.3%) discontinued ibuprofen because of GI intolerance.

"Any drug used in the control of the symptoms of the chronic arthritis must be tolerated for long periods without undue gastric discomfort...From this study it appears that ibuprofen is eminently suitable."⁸

Peptic ulceration and GI bleeding, sometimes severe, have been reported. Rufen[®] should be given under close supervision to patients with a history of upper GI tract disease.

References: 1. Royer GL, Jr, Moxley TE, Hearron MS, et al: *J Int Med Res* 3:158-171, 1975. 2. Royer GL, Jr, Moxley TE, Hearron MS, et al: *Curr Therap Res* 17:234-248, 1975. 3. Brackertz B, Busson M: *Brit J Clin Pract* 32:77-80, 1978. 4. Tausch J, Fasching U: *Brit J Clin Pract: A symposium supplement, IXTH European Congress of Rheumatology*, Wiesbaden, Germany, Sept 2-8, 1979, pp 53-61. 5. Lanza FL, Royer GL, Jr, Nelson RS et al: *Dig Dis & Sci* 24:823-828, 1979. 6. Pavelka K, Susta A, Vojtisek A et al: *Rheumatol and Rehab* 12:68-73, 1973. 7. Tretenhahn W: *Brit J Clin Pract: A symposium supplement, IXTH European Congress of Rheumatology*, Wiesbaden, Germany, Sept 2-8, 1979, pp 45-52. 8. Cardoe N: *Curr Med Res & Opinion* 3:518-520, 1975.



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RUFEN[®] (ibuprofen) Tablets

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain. Treatment of primary dysmenorrhea

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angio-edema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the AVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin: Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS: Incidence greater than 1%. **Gastrointestinal:** The most frequent adverse reaction is gastrointestinal (4 to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS). *Incidence 3% to 9%.

Incidence less than 1 in 100. Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome and alopecia. **Special Senses:** hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) [see PRECAUTIONS]. **Hematologic:** neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive) thrombocytopenia with or without purpura eosinophilia, decreases in hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Allergic:** syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasms (see CONTRAINDICATIONS). **Renal:** acute renal failure in patients with preexisting significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. **Miscellaneous:** dry eyes and mouth, gingival ulcers, rhinitis.

Causal relationship unknown. Gastrointestinal: pancreatitis. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri. **Dermatologic:** toxic epidermal necrolysis, photo-allergic skin reactions. **Special Senses:** conjunctivitis, diplopia, optic neuritis. **Hematologic:** bleeding episodes. **Allergic:** serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (sinus tachycardia, bradycardia, and palpitations). **Renal:** renal papillary necrosis.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine; alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Dysmenorrhea: 400 mg every 4 hours as necessary.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for the relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage. Cefaclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococcus). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

Contraindication. Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS. CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: General Precautions—If an allergic reaction to Cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefaclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinette® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cefaclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Cefaclor have been detected in the milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefaclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.⁷

Cefaclor®

cefaclor

Pulvules®, 250 and 500 mg

hour. The effect on nursing infants is not known. Caution should be exercised when Cefaclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Cefaclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis, arthralgia, and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefaclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome. Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(061782R)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefaclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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8. Principles and Practice of Infectious Diseases (edited by G. L. Mandel, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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NEWSLETTER

April 1983

Dear Doctor:

The annual meeting of the Mississippi Foundation for Medical Care will have a format that few organizations dare to offer! The meeting will be devoted to an open session for members of the Foundation to express their views on what the organization is doing right or wrong.

Are you mad or glad about PSRO? Come to the annual membership meeting of the MFMC and tell everyone why. The meeting will begin at 1:00 p.m., Thursday, May 12, at the Royal d'Iberville Hotel in Biloxi. (P.S. No guns will be allowed inside the meeting hall!)

The MFMC is one of a number of medical related organizations which have scheduled meetings in conjunction with the MSMA's upcoming 115th Annual Session. Preliminary information about the Annual Session program is included in this issue, and copies of the complete program will be mailed to members later this month. Early registration indicates there will be a record number of members, spouses and guests attending this year's meeting.

The MSMA is one of 31 states which will have additional AMA delegates this year. Elections to fill that post and other MSMA offices will be held during the Annual Session. The list of candidates selected by the Nominating Committee is included in this issue of Journal MSMA.

Interested MSMA members will receive information later this month about an association Benefit Plan and Trust offering health and life insurance to members, employees of members and their families. An open enrollment period will be conducted through May 31. The plan will be administered by MSMA under direction of a Benefits Committee composed of participating physicians. Premiums charged by the plan are expected to be below those currently available.

Annual re-registration of Mississippi medical licenses for 1983-84 will begin May 1. Dr. Frank Morgan, executive officer of the Mississippi State Board of Medical Licensure, has advised that at the January 20 meeting of the Board, members voted unanimously to reduce the renewal fee from \$50 to \$40. Deadline for renewal is June 30.

Sincerely,



Patsy Silver
Managing Editor

Pinworms work the night shift



Artist's interpretation:

The nocturnal egg-laying of the female pinworm causes acute perianal itch...making children shift sleeplessly through the night.



Put pinworms out of work...

Promptly paralyzes pinworms and roundworms

Antiminth® (pyrantel pamoate) has a unique, rapid immobilizing effect on worms. Unlike mebendazole, which blocks glucose uptake—slowly “starving” helminths to death—Antiminth quickly acts on the neuromuscular junction to promptly paralyze parasites.

97% efficacy with a single dose

A single dose of Antiminth delivers rapid clinical and parasitological cures, “Single doses... showed high overall efficacy against *Enterobius vermicularis* (97.2%) and *Ascaris lumbricoides* (97.5%).”¹

Simple, well tolerated therapy

Antiminth offers ease of administration and patient tolerance. “...when compared to the other single dose agents available, [Antiminth] has the advantage of being non-staining and may be better tolerated.”²

The dosage form children like

Antiminth is available as a pleasant tasting, caramel-flavored oral suspension. Effective in just



one dose against pinworm and roundworm—in both children and adults—Antiminth is easy-to-administer and easy-to-take.

Respected around-the-world

In some parts of the world, large populations are afflicted with helminthic infections. Physicians in endemic areas have become experts on parasitic diseases—and have come to rely on Antiminth for the rapid cure of infestations. Antiminth is recommended as an agent of first choice for pinworm and roundworm by leading medical authorities.³

Warnings

Usage in Pregnancy Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known. There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions

Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions

The most frequently encountered adverse reactions are related to the gastrointestinal system. Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration

Children and Adults Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

References 1. Pitts NE, Migliardi JR: *Clinical Pediatrics* 13:87, 1974. 2. Modell W: *Drugs of Choice* 1980-1981. C. V. Mosby Co., St. Louis, 1980, p. 362. 3. Goodman LS, Gilman A: *The Pharmacologic Basis of Therapeutics*, 6th edition, MacMillan Publishing Co., Inc., New York, 1980, p. 1032.




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Cures pinworm and roundworm fast...with a single dose



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Many patients presented with physical symptoms are suffering from psychiatric illness, but are unaware of it. And while not all who suffer from mental illness or emotional problems need hospital treatment, hospitalization may be essential to provide a therapeutic environment in which the patient can effectively deal with his or her problems.

Riverside Hospital is a 56-bed, short-term care facility which provides intensive treatment of patients suffering from psychiatric illnesses, alcoholism, and drug dependencies. In Riverside's open, non-institutional environment, traditional and new, progressive psychotherapies are utilized.

Above all, care at Riverside is aimed at treating the patient with respect and dignity, fostering self-esteem, and returning the patient to independence and a satisfying, productive and happy life.

Riverside is licensed by the Mississippi Commission on Hospital Care, and is fully accredited by the Joint Commission on Accreditation of Hospitals.

The medical staff includes a large number of psychiatrists in private practice in the Jackson area. A toll-free number, 1-800-962-2180, has been established at the hospital for referral service to physicians on the active medical staff.

Physicians who have patients who would benefit from the type of treatment approach offered by Riverside may obtain referral information by contacting the Director of Admissions.

 **Riverside Hospital**

P. O. Box 4297, Jackson, Mississippi 39216

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DATELINE

Legislature Passes
Tougher DUI Law

Jackson, MS - Governor Winter is expected to sign the compromise DUI legislation which passed the Legislature by a margin of six votes. House and Senate conferees reached agreement on the matter of license suspensions for first time offenders. The legislation which was adopted imposes tougher penalties for DUI convictions, including mandatory 45-day suspension of a driver's license before application can be made for "hardship" claim.

MD Increase Exceeds
Population Growth

Chicago, IL - The number of U.S. physicians is increasing faster than the population in general. Between 1976 and 1981, the number increased by 18.5% while the general population rose 5.4%, according to the AMA Physician Masterfile. The number of women physicians increased by 53.1% during that period. At the end of 1981 there were 485,123 medical doctors, 230.5 million people, and an average of 210.4 physicians for every 100,000 population.

Ectopic Pregnancies
Are Increasing in U.S.

Chicago, IL - Both the numbers and incidence of ectopic pregnancies are on a dramatic upward spiral in the U.S., according to a report in the April 1 issue of JAMA. The number of ectopic pregnancies rose from 17,800 in 1970 to 42,000 in 1978, and the incidence more than doubled, from 4.5 per 1,000 to 9.4 during the same period, reported researchers from the Centers for Disease Control. Deaths have declined, however, by 75%.

Newsbriefs From
Dept. of HHS

Washington, DC - Briefs from the Dept. of Health and Human Services...Last month Margaret M. Heckler was sworn in as Secretary after the Senate confirmed her nomination with three dissenting votes...HHS has issued an interim final rule prohibiting discriminatory failure to feed and care for handicapped infants...The Secretary's Initiative on Teenage Alcohol Abuse was kicked off last month with a national conference which focused on approaches to combat the problem.

AMA Membership Up
Despite Dues Increase

Chicago, IL - Last year was the first time that AMA membership rose despite an increase in dues. Although regular full membership dues were increased from \$250 to \$285, total membership rose to 249,908 from 239,277 in 1981. By category, regular full and reduced-dues membership rose by 2,829, housestaff by 3,997, and medical student membership by 4,111. For 1983, full dues have been raised from \$285 to \$315, part of an incremental increase program adopted in 1981.

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Prescribe for your patients as you would for yourself.

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ORIGINAL PAPERS

Splenorrhaphy, Not Splenectomy

LEWIS E. HATTEN, M.D., J. P. CULPEPPER, III, M.D., and
J. E. VARNER, JR., M.D.
Hattiesburg, Mississippi

IN 1952 KING AND SCHUMACHER reported the unusually high incidence of overwhelming bacterial infections in children who had undergone splenectomy. Although initially this was viewed with skepticism, over the past several years this concept has led to universal acceptance of splenic salvage in children.¹

Presently there are also reports in the literature extrapolating this concept of splenic salvage to adults. The non-splenectomy approach to the traumatized spleen in children has been advocated as both safe and reasonable, and has become an acceptable mode of treatment.²

The present report reviews eleven consecutive cases of splenic trauma in our private surgical practice in a community hospital setting.

Clinical Data

Eleven patients were admitted to the Forrest General Hospital or the Methodist Hospital in Hattiesburg, Mississippi, ranging in age from 5 years to 68 years. Five patients were male and six were female. In one patient, splenic injury resulted from iatrogenic trauma associated with left hemicolectomy; the other ten resulted from blunt abdominal trauma. Treatment period was from November, 1979, through January, 1982.

Treatment and Results

During the review period of twenty-seven months all eleven patients underwent exploratory lapa-

rotomy and were found to have some type of splenic injury. In a single case, extensive other abdominal injuries as well as a severely macerated spleen dictated that splenectomy be carried out rather than an attempt at splenic salvage. In the other ten patients, splenic repair was effected. Surgical technique involved a long mid-line incision, then a rapid assessment of the origin of the intra-abdominal hemorrhage, and appropriate treatment of any other visceral injury. Suture utilized in splenic repair was usually a 2-0 or 3-0 chromic catgut. We realized early in our attempts to suture the spleen that braided materials seemed to have a "sawing effect" and resulted in excessive bleeding as the suture passed through the pulp and also seemed to be more difficult to tie. The monofilament synthetics such as prolene could not be tied tightly enough to satisfy or pacify us. We also found that microfibrillar collagen or Surgicel® would be helpful in stopping bleeding from the suture holes in the pulp of the spleen. Electrocautery was found not to be very effective as opposed to bleeding from the liver.

Follow-up on these patients has ranged from two months to two years. There have been no initial complications such as re-bleeding or "delayed capsular rupture"; and no sub-diaphragmatic abscess or other infection. There were no deaths in the series. There have been no long-term post-operative complications that can be related to the splenic repair in any of the cases. All patients reported are living and well as of this writing.

Discussion

Arguments regarding the current treatment of the

Drs. Hatten, Culpepper and Varner are engaged in the private practice of surgery in Hattiesburg, MS.

SPLENORRAPHY / Hatten et al

injured spleen have raged for years, some having been documented in the writings of Aristotle, then Sir Christopher Wren, and Morgagni. It has always been thought that the spleen was non-essential to life, but in 1919 it was concluded that a person deprived of his spleen would have an increased susceptibility to infection.³

This concept, however, was either unnoticed or disregarded for many years. As late as the mid-1970s leading surgical textbooks suggested that the preferred method of treatment for the traumatized spleen was splenectomy.⁴ With increasing knowledge of physiologic and immunologic functions of the spleen, it has become apparent in the last ten years that preservation of splenic tissue is important. The spleen acts as (a) an immunologic filter for particulate antigens, (b) a manufacturer of IgM antibodies against circulating antigens, (c) a producer of opsonins to aid in promoting phagocytosis by white cells, (d) a regulator of T & B lymphocytes.¹ The absence of the spleen thus makes the asplenic individual obviously very susceptible to blood-borne infections. While responding normally to subcutaneous antigens and intravenous soluble antigens, they are vulnerable to overwhelming infec-

tions; most commonly associated with the *Pneumococcus*, *Meningococcus*, and *Hemophilus influenza* bacteria groups.³

In the classic article by Lynn, the attack rate for infection on the "Thousand Family Survey" was 0.7 percent and in children with intact spleens the rate was 0.3 percent in the first year of life, 0.07 percent between 1 and 7 years, and 0.02 percent between 7 and 14 years of age.³

In a review of 2,769 splenectomized cases by Singer, sepsis was found to have occurred in 119 or 4.25 percent of patients. Seventy-one (2.52 percent) died. In view of these statistics, it is apparent that the mortality from overwhelming sepsis varies from about 50 to 200 times more frequently in the splenectomized individual than in the population at large.

The mode of death in these cases was usually pneumococcal septicemia, complicated by DIC and adrenal failure.³

For some reason, there is an increased susceptibility to sepsis in the patient who has undergone splenectomy for a hematologic disorder rather than associated with trauma. There does not, however, seem to be any time limit beyond which the splenectomized individual becomes less susceptible. It seems, therefore, that from a physiologic and immunologic viewpoint that the goal of the surgeon

SPLENIC TRAUMA — JANUARY, 1979-NOVEMBER, 1982

Patient	Age	Sex	Type of Injury	Treatment	Results Complications	Death
J R.	17	M	Motor Vehicle Accident	Splenorrhaphy 2-0 Chromic	None	No
R. B.	15	F	MVA Multiple Injuries	2-0 Chromic	None	No
G. H.	28	M	Home Accident Isolated	3-0 Chromic	None	No
M. H.	5	M	Home Accident	2-0 Chromic	None	No
W. B.	68	F	Iatrogenic	3-0 Chromic	None	No
M. T.	23	M	MVA Multiple Injuries	2-0 Chromic	None	No
S. C.	16	F	MVA Isolated Injury	2-0 Chromic	None	No
R. B.	16	F	MVA	3-0 Chromic	None	No
D. L.	30	M	MVA	2-0 Chromic	None	No
T. B.	24	F	MVA Multiple Injuries	2-0 Chromic	None	No

should be to conserve splenic tissue.² Splenorrhaphy rather than splenectomy also becomes significant from a legalistic point of view in that at least one lawsuit recently has been filed based specifically on the loss of the protective spleen in an injured patient. This is even more implicating when the spleen is removed "incidentally" for iatrogenic trauma. In our view, the aim of therapy should be conservation of splenic tissue whenever possible; and if not at all possible, clear documentation regarding the necessity for its removal is indicated. A statement to this effect in the chart would not only be of benefit for the protection of the operating surgeon but also for the future protection of the patient with a traumatized spleen. ★★★

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Congenital Syphilis

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DRAMATIC INCREASES in the rate of syphilis in the United States mean that more cases of congenital syphilis will be seen. It is essential that practitioners recognize the signs of neonatal syphilis and treat with penicillin as soon as possible. In this seminar a case of fatal congenital syphilis is presented.

Dr. Friedman: A teenage unmarried mother at 34 weeks gestation and without prenatal care presented in early labor to the emergency room of this hospital. Fetal heart tones were 80/min and the baby was taken by emergency cesarean section. At delivery the baby was flaccid, cyanotic and apneic with a heart rate of 60/min. Hydrops fetalis was present. The baby was resuscitated in the delivery room, taken to the nursery and placed on mechanical ventilation. Physical examination found the patient to be an 1175 gram hydropic infant with massive hepatosplenomegaly. Heart rate was 120/min, blood pressure 45 systolic. There was no spontaneous activity except an occasional gasp. Ecchymoses were noted over the belly, axillae and extremities. There was fixation — flexion of the right elbow, wrist and index finger and talipes equinovarus was present. The right atrial pressure measured with an umbilical catheter was 1-2 cm water. The infant received volume expansion, 150 mg ampicillin and 2.5 mg gentamicin intravenously.

The initial WBC was 30,300 with 24% segmented neutrophils, 0% bands, 62% lymphocytes, 7% monocytes and 45 nucleated red cells/mm³. The Hgb was 8.9, Hct 29.9 and platelet count 87,000/mm³. Arterial blood gases showed severe respiratory acidosis. The mother was O positive, the baby was A positive and the Coombs test was negative. An X-ray of the chest was obtained.

From the Newborn Division, Mississippi Baptist Medical Center and the Department of Pediatric Radiology, University Medical Center, Jackson, MS.



Figure 1. Chest x-ray demonstrating massive organomegaly and loss of lung volume due to enlarged abdomen.

Dr. Blumenthal: The initial radiograph (see Figure 1) shows the baby is hydropic. There appears to be some possible splenomegaly but definitely hepatomegaly is present. There is some indistinctness of the margins of the right hemidiaphragm which is elevated, and loss of right middle and lower lobe volume. The endotracheal tube is a little deep with partial occlusion of the terminal right bronchus. The diaphragm is high from abdominal distension.



Figure 2. Close-up x-ray view of the right shoulder showing a distorted and notchy appearance of the humerus, characteristic of congenital syphilis.

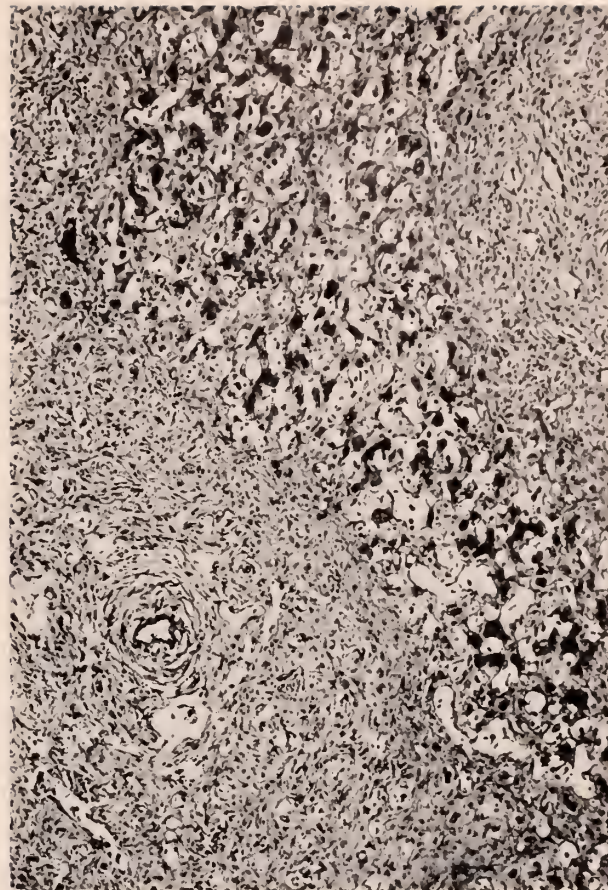


Figure 3. Photomicrograph of the liver enlarged $\times 100$ showing marked distortion of the lobular pattern due to replacement by connective tissue.

The right proximal humerus is ragged-looking; the trabecular pattern is distorted and notchy; ill-defined areas of lucency in the proximal metaphysis of the humerus and femur suggests congenital syphilis (see Figure 2).

Dr. Friedman: Despite attempts to ventilate and oxygenate, the patient died of respiratory failure one hour after birth.

Autopsy report (Dr. Louis Schiesari, Division of Pathology, Mississippi Baptist Medical Center): The RPR serum was strongly positive at $> 1:256$ dilution. All blood cultures were negative. Pertinent findings in the internal organs are consistent with congenital syphilis and include hepatosplenomegaly. Microscopic sections of the liver show marked distortion of the lobular pattern due to massive increase and replacement by connective tissue (see Figure 3). The lungs show a poorly-developed alveolar pattern with a sprinkling of round cells seen in the parenchyma. Lymphocytes and plasma cells . . . are also seen in a mild infiltrate of the subepicardial layers of the heart.

Dr. Friedman: Reported cases of syphilis have risen dramatically over the past three years, from 9.5

per 100,000 in 1977 to 12.0, or 27,204 new cases in 1980.¹ Case rates have more than doubled in Mississippi and remain twice as high as the national average. Nearby cities of Memphis and New Orleans are among the highest in the nation with rates of 87.1 and 95.6 per 100,000, respectively. Nevertheless it is remarkable that Mississippi has reported one of lowest rates of congenital syphilis, 6.6 per 1000 primary cases. The marked discrepancy between case rates of adult-onset and congenital syphilis in Mississippi may reflect either widespread prenatal serologic testing and epidemiologic follow-up or gross under-reporting of congenital infection due to lack of recognition of the disorder in the newborn.

In the case presented here a pregnant woman had probably acquired syphilis several weeks to months prior to this preterm delivery at 34 weeks. Since she sought no prenatal care, her fetus was doomed. In cases where infection occurs prior to delivery, rapid diagnosis and treatment are essential.

The presenting signs of congenital syphilis are often subtle. Syphilis does not usually cause severe intrauterine growth retardation, although the fetus may die in utero. In a living child often born prematurely no hepatosplenomegaly may be present at birth. Enlargement of the liver and spleen occurs from one to four weeks after infection. Peeling of the skin of the hands and feet, polymorphic rashes and mucus membrane lesions including rhinorrhea ("snuffles") may be noted at birth. Careful examination of the bones as seen in the x-rays presented here will usually show the subtle signs of periostitis and osteochondritis. Unlike toxoplasmosis and cytomegalovirus, common chronic intrauterine infections, syphilis rarely can be identified on ophthalmological examination.

This case is an unusual but important manifestation of congenital syphilis: hydrops fetalis. Hydrops, or massive, total body edema, is most often associated with Rh-isoimmune hemolytic anemia. In this case, isoimmune disease was absent. Nevertheless, the infant had a severe hemolytic anemia with Hematocrit 29.9 and 45 nucleated red cells/mm³. Hemolytic anemia as well as thrombocytopenia can occur in 50-75% of cases of congenital syphilis. Myocarditis found at autopsy in this case may have contributed to the hydrops.

A positive RPR is required for a definite diagnosis. Penicillin in doses of 50,000 to 100,000 units/kg should be given when the diagnosis is suspected.

Before the discovery of penicillin, congenital syphilitic pneumonia was the second most commonly recognized cause of neonatal pneumonia, after the Group A streptococcus.

All women should have at least two RPR tests, one in early and one in late pregnancy. After birth no infant should be discharged from the hospital without a documented negative maternal RPR at delivery. Should an asymptomatic infant have a positive RPR, a lumbar puncture should be done to rule out spinal fluid pleocytosis which would be suggestive of neurosyphilis. Maternal IgG against the spirochete will be transported to the fetus with titres equal to those of the mother so that the presence of a positive RPR in an infant does not necessarily prove fetal infection. A rising follow-up titre in three-four weeks after delivery will define a congenitally acquired infection. Because of uncertainty in excluding late-trimester onset syphilis in an inadequately-treated mother or fear that the infant may be lost to follow-up, we have been treating all infants with positive RPRs according to the schedule of McCracken et al:² 50,000 units/kg of benzathine penicillin IM in asymptomatic infants with normal spinal fluid; 50,000 units/kg/day of penicillin G in two divided doses for 10 days for symptomatic infants and infants with CSF pleocytosis.

Surviving infants untreated or partially treated for congenital syphilis will be afflicted with psychomotor retardation, sensorineural hearing loss, cranial and peripheral nerve palsies, teeth, bone and joint diseases. Because early treatment is curative, congenital syphilis should be excluded in every newborn. All infants with congenital syphilis must be reported to the State Health Department. ★★

Dr. Friedman: 1850 Chadwick (39204)

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Shroud of Turin

The Shroud of Turin, believed by many to be the burial garment of Jesus Christ, bears the image of a human body. Dr. Robert Bucklin, a member of the research team which investigated the ancient linen cloth in 1978, described some of the researchers' findings. His address was the second annual James Grant Thompson Memorial Lecture, presented at the 114th Annual Session.

The Shroud, pictured at right, was damaged by fire in 1532. The dark vertical marks resulted from that damage, and the eight triangular shaped marks are patches sewn into the fabric in an effort to repair it.



The Shroud of Turin: A Pathologist's Viewpoint

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FOR MANY CENTURIES, a piece of linen cloth, 4.3 x 1.1 meters in size and bearing the frontal and dorsal images of a human body, has been kept in Turin, Italy. Individual and group scientific studies have been performed on this cloth, known as the Shroud of Turin, the most exhausting of which was done in 1978.¹

Prior to 1978, nearly all studies of the Shroud of Turin were based on examination of photographs, the best of which were those prepared by G. Enrie in 1931. As a result of those studies, there has been general agreement among medical investigators that there is a human image and blood deposits on the cloth. These opinions were based on the physical appearance of the image and the stains considered to be blood. The body image is that of an adult human male. The proportions of the body are generally realistic and support the anatomic opinion that the image represents a human form. There are no elements of the image which do not conform to this conclusion, and there are many features of the figure which are typical of a human. Details of facial features, including eyes, nose and hair are examples. The outlines of the upper and lower extremities, as well as the chest, abdomen and back are clearly those of a human. The umbilicus can be identified and is in its proper anatomic location. The genital area is covered by the image of the crossed hands so that no details are seen. It is not within the scope of this paper to discuss the theories of origin of the body image on the cloth, but there is no doubt that contact between the body and the cloth was a most important factor in the development of the image and the trans-

Interest in the Shroud of Turin drew nearly 800 people to the Gulf Coast Convention Center last year for a special public presentation of the James Grant Thompson Memorial Lecture.

fer of blood from body to cloth.²

The characteristics of bloodstains are quite clear and these blood deposits are in sharp contrast to the imprint of the body outline. In many instances, the bloodstains overlie the body imprint, while in other places on the cloth, they appear outside the body image. The origin of these spatially removed stains cannot be fully explained at this time. Positioning of the body during its placement in the burial cloth may account for some of them. There is evidence to suggest that some of the blood deposits on image areas antedate the development of the image. A study is now underway to try to explain the pathophysiology of blood shedding in light of fibrinolytic actions and liquefaction of clots, and the possible role of intravascular coagulation in these events.

Evaluation of Bloodstains

With color photos prepared by the Shroud of Turin Research Project in 1978, the evaluation of the bloodstains becomes more precise. The photographic material, particularly those pictures which accentuate the red color of the bloodstains, brings out details of the stains very clearly. There is a distinct difference in the color of the body image and the stains representing blood deposits, with a definite carmine-red color in the latter. Enhancement photos made with the Digital Image Analysis and Display System show considerable internal struc-

Read before the 114th Annual Session of the Mississippi State Medical Association, May 2, 1982, in Biloxi, MS. The article was printed in part in *Legal Medicine* 1982, published by W. B. Saunders.

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tures of the blood prints, with physical separation of red blood cells from serum and localization of the cells toward the periphery of the blood deposits.

In 1980, Heller and Adler reported the finding of blood on fibers taken from the shroud, based on spectroscopic and chemical tests which identify a porphyrin.³ Later testing by the same authors has confirmed the presence of hemochromogen, protein and serum albumin.

Evidence of Crucifixion

The imprint on the burial cloth outlines the body of an adult male, 71 inches in height and weighing an estimated 160 to 170 pounds. The general appearance of the body indicates stiffness, suggesting that rigor mortis is present. There is much physical evidence to show that the individual whose image appears on the shroud has been crucified and that his wrists, feet, chest, head, and large parts of his skin have been injured by a variety of objects. To a pathologist, the blood deposits and stains which reflect injuries to the body are of great interest.^{4, 5} A number of these are characteristic enough to permit an interpretation of their probable cause. There are some markings which reflect abrasions and contusions and others which indicate punctures and outflow of blood from cavities. Some markings on the image are good examples of patterned injuries.

The injuries on the body can best be divided into five groups: the marks on the skin, piercing lesions in the wrists, similar injuries in the feet, wounds on the head, and the wound in the chest. Each of these groups will be analyzed in some detail.

Marks on the Skin

The marks on the skin appear on the anterior chest as well as the back of the body, where they extend from the shoulders to the calves. On the back, the imprints appear in a sheaf-like fashion directed downward and medially from the shoulders. Each of the marks consists of two portions, indicating that the instrument used was bifid. There are indented bleeding points at each of these sites and by ultra-violet fluorescence contrast the marks resolve into scratch-like linear lesions, each with three or four parallel elements. Some of the other blood deposits on the Shroud show a pale aura around the area, suggesting a separation of serum from other blood components. While the lower extremities are involved by these injuries, none are present on the arms or forearms. The appearance of these wounds

is consistent with the application of a whip-like device having sharp or rounded ends which tore the skin in a characteristic fashion. The marks are difficult to count but they number at least 100.

Two large discolored areas over the shoulder blades are consistent with bleeding from surface abrasions as if a heavy, rough object had been in contact with the skin at these points. From what is known about crucifixions, it was the custom for the crossbar of the cross to have been carried by the victim, supported across the upper back and shoulders. It is quite likely that it was this sort of structure which produced the abrasions over the scapulae.

Piercing Wounds in the Wrists

The imprints of the hands show that they are crossed with the left hand covering the right wrist. The outlines of four fingers are clear but there are no imprints left by the thumbs. In the left wrist area, there is a bloodstain which is composed of two projecting rivulets from a central source and separated by about a ten degree angle. That this bloodstain is not in the palm of the hand can be determined by simple measurement taken from a site of the mark to the tips of the fingers. It is too far from the fingertips to be in the palm. A nail can be easily driven through the bones of the wrist separating these bones but not producing fractures. This was done experimentally by Barbet⁶ and has been repeated by others. Since the right wrist is covered by the left hand, no puncture mark is visible on the right wrist. The fact that on the imprint of the hands no thumbs are clearly visible is explained by the penetrating pointed objects passing through the wrists, having damaged the median nerve. The motor function of the median nerve is to produce flexion of the thumb. The thumb may either be adjacent to the hand or flexed over the palm.

From the angulation of the stain on the wrist as well as the direction of flows of blood on the forearms, it is possible to approximate the position of the victim at the time of the injury and subsequent blood flow. Blood follows the laws of gravity, and if one were to extend the arms laterally until the bloodstains appear vertical, it would show that the arm position was approximately 25 degrees above the horizontal at the time of the blood flow. The divergence of the streams suggests that two positions were maintained by the victim during the period of the blood flow. The difference in angulation is about ten degrees and can be explained by the victim elevating his body by directing his weight toward the feet and then changing position to permit the full body weight to be supported by the wrists.

Wounds in the Feet

A study of the imprints of the feet is somewhat less complicated. On the shroud, there are two prints representing the marks left by blood-covered feet. The imprint of the right foot is a nearly complete one in which the outline of the heel and toes can be seen. In the area corresponding to the metatarsal zone is a square image surrounded by a pale halo, and this represents the place where the foot has been pierced. The imprint of the left foot is less clear. Examination of the calves of the legs on the dorsal view shows that the right calf has left a well-defined outline in which the marks of the whip can be seen. The imprint of the left calf is much less distinct. This, coupled with the fact that the left heel is elevated above the right heel, leads to the conclusion that there is some degree of flexion of the left leg at the knee.

From the physical appearance of the footprint stains it appears that the right foot was directly against the surface of the cross and the left leg was flexed at the knee and the foot rotated so that the left foot rested on the instep of the right foot. The right foot became completely covered with blood while the left foot did not. A single impaling sharp object like a nail was used to fix both feet in position, passing between the metatarsal bones. One medical investigator has presented evidence that both feet may have been impaled separately rather than together.⁷

Injuries About the Head

The fourth group of injuries are those about the head. On the front portion of the forehead are several blood prints, one of which assumes the appearance of the figure 3. This was formed by the blood flow following the normal skin creases of the forehead. Circling the scalp posteriorly is a row of blood prints and high on the scalp at the vertex are similar prints. Any puncture of the scalp ordinarily produces bleeding excessively because of retraction of torn vessels. To account for all the bloodstains on the head, one must assume that more than a simple circlet of sharp, pointed objects were used. A cap-like structure with thorns at the center and periphery would account for the bloodstains on these portions of the head.

On the face over the right cheek, there is a swelling and there is partial closure of the right eye. There is a very slight deviation of the nose and at the tip of the nose is an area of discoloration consistent with a bruise. Detailed photographs and microscopic studies of the cloth in the nose image area show scratches and dirt. These are consistent with the nose having made contact with the ground, most likely as the

result of a fall. The deviation of the nose may reflect injury to the nasal cartilage, although this is less clear.

Chest Wound

The largest bloodstain on the burial cloth is on the right side of the chest. It covers the area of the fifth and sixth ribs. This stain very clearly shows separation of blood from a clear watery material. Some of the latter may be serum, but there seems to be much more of it than can be explained by a simple process of serum release from a blood clot. Early investigators, including Barbet⁶ and Judica-Cordiglia,⁸ believed that the blood came from the right side of the heart and that the water was fluid from the pericardial sac. It is well-known that the pericardial sac contains a very small quantity of fluid, rarely more than 30 to 50 ml. This would hardly seem to be an adequate source to account for the amount of watery fluid on the Shroud. One of the theories of the origin of blood and water was presented by Sava.⁹ He quotes the experience of physicians who treat severe chest injuries and the frequency of non-penetrating injuries to the chest producing accumulation of bloody fluid in the pleural spaces around the lungs. Since red blood cells gravitate to the bottom of the cavity, there is accumulation of the lighter serum at the upper part of the chest cavity. Sava's concept was that the piercing of the chest resulted first in an outflow of the settled bloody portion of the effusion followed by release of a clear fluid as the level of fluid in the chest cavity was lowered. While this is a very plausible explanation of the sequence of events, there is one which is more realistic. With the exception of the whip-like injuries in the area of the upper back and chest, there is little evidence of direct trauma applied to the thoracic area. This would seem to refute one of the requirements put forth by Sava that there be severe chest injury. Accumulation of clear serous fluid in the pleural space is very frequent and occurs under a variety of situations. It may be caused by a simple irritation of the pleura and, much more likely, by congestion related to failure of the cardiovascular system. Because of the posture of the suspended crucifixion victim, it is likely that some degree of congestive heart failure occurred. One of the earliest signs of this is the accumulation of clear fluid in the pleural spaces as well as in other body cavities, including the pericardial sac. In such a situation, if there were perforation by a sharp pointed object to the rib cage into the pleural space, there would be an outflow of clear fluid. If the piercing object were then to be pushed further into the chest, it would penetrate the pericardium and the

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right side of the heart and release a quantity of blood. This combination of blood and water would account for the stain on the front of the chest as well as the heavy stains which appear over the lower back.

The most logical mechanism for death by crucifixion is development of respiratory asphyxia related to failure of the cardiovascular system from shock and pain. The posture of the victim, the duration of the suspension, and the lack of adequate support for the body weight all serve to promote a condition of diminished respiratory capacity, resulting in cardiac failure and subsequent fluid accumulation in body cavities.

Summary

In summary, this has been an analysis of the medically significant imprints on the Shroud of Turin by a forensic pathologist with suggestions as to their probable cause. It is a scientific and objective presentation with no direct attempt at correlation

between the Shroud imprints and New Testament accounts of the crucifixion of Christ. However, the author cannot help but comment that a remarkable consistency exists between the gospel accounts and the forensic pathological findings depicted on the Shroud of Turin. ★★★

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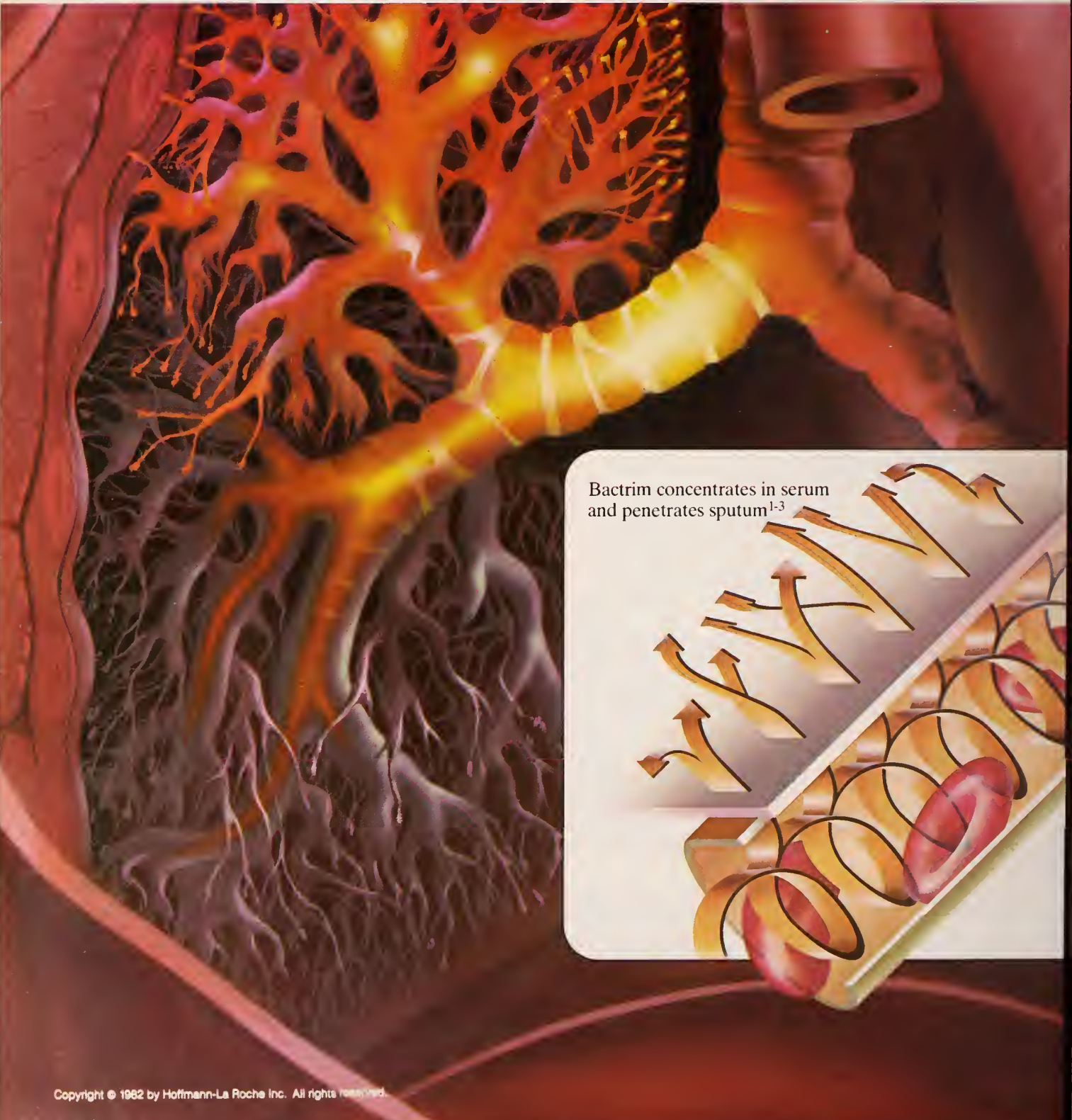
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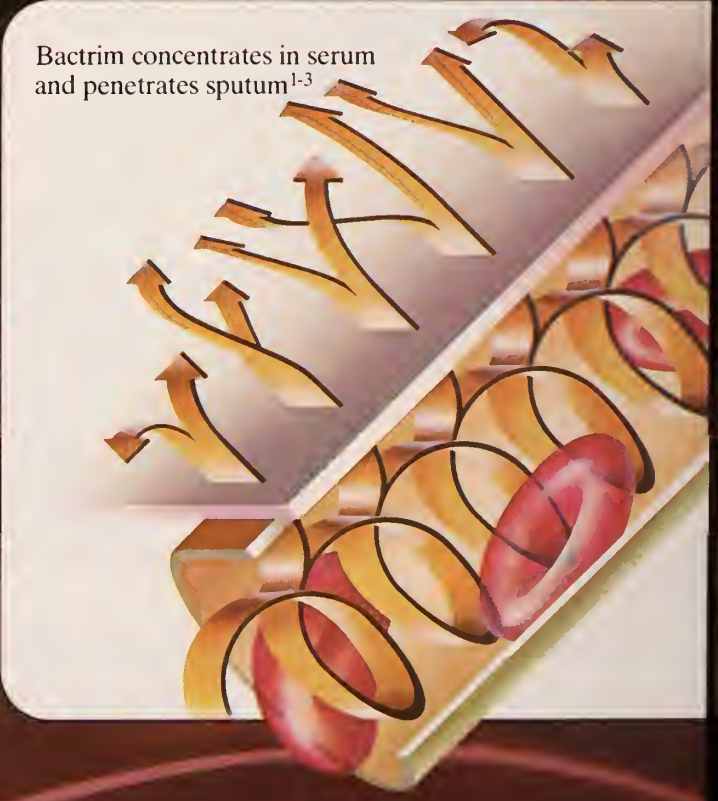
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major pathogens of chronic bronchitis*

Bactrim clears sputum of susceptible bacteria

In sputum cultures from patients with acute exacerbations of chronic bronchitis, *H. influenzae* and *S. pneumoniae* are isolated more often than any other pathogens.^{4,5} One study of transtracheal aspirates from 76 patients with acute exacerbations found that 80% of the isolates were of these two pathogens.⁵

Bactrim is effective *in vitro* against most strains of both *S. pneumoniae* and *H. influenzae*—even ampicillin-resistant strains. And in acute exacerbations of chronic bronchitis involving these two pathogens, sputum cultures taken seven days after a two-week course of therapy showed that Bactrim eradicated these bacteria in 91% (50 of 55) of the patients treated.⁶

Bactrim reduces coughing and sputum production

In three double-blind comparisons with ampicillin *q.i.d.*, Bactrim DS proved equally effective on all clinical parameters.⁷⁻⁹ Bactrim reduced the frequency and severity of coughing, reduced the amount of sputum produced and cleared the sputum of purulence.

Bactrim has the added advantages of *b.i.d.* dosage convenience and a lower incidence of diarrhea than with ampicillin, and it is useful in patients allergic to penicillins.

Bactrim also proved more effective than tetracyclines in 10 clinical trials

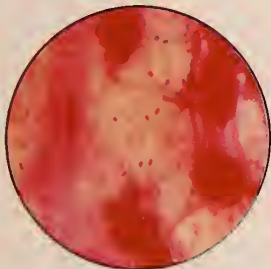
involving nearly 700 patients.¹⁰ Overall clinical condition of the patients, changes in sputum purulence, reduction in sputum volume and microbiological clearance of pathogens—all improved more with Bactrim therapy than with tetracyclines. G.I. side effects occurred in only 7% of patients treated with Bactrim compared with 12% of tetracycline-treated patients. (See Adverse Reactions in summary of product information on next page.)

Bactrim is contraindicated in pregnancy at term and nursing mothers, infants under two months of age, documented megaloblastic anemia due to folate deficiency and hypersensitivity.

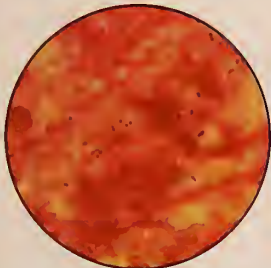
Bactrim DS. For acute exacerbations of chronic bronchitis in adults* when it offers an advantage over single-agent antibacterials.

References: 1. Hughes DTD, Bye A, Hodder P: *Adv Antimicrob Antineoplastic Chemother* 1/2:1105-1106, 1971. 2. Jordan GW et al: *Can Med Assoc J* 112:91S-95S, Jun 14, 1975. 3. Beck H, Pechere JC: *Prog Antimicrob Anticancer Chemother* 1:663-667, 1969. 4. Quintiliani R: Microbiological and therapeutic considerations in exacerbations of chronic bronchitis, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts*; Princeton Junction, NJ, Communications Media for Education, Inc., 1980, pp. 9-12. 5. Schreiner A et al: *Infection* 6(2):54-56, 1978. 6. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 7. Chodosh S: Treatment of acute exacerbations of chronic bronchitis: results of a double-blind crossover clinical trial, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts*. *Op. cit.*, pp. 15-16. 8. Chervinsky P: Double-blind clinical comparisons between trimethoprim-sulfamethoxazole (Bactrim™) and ampicillin in the treatment of bronchitic exacerbations. *Ibid.*, pp. 17-18. 9. Dulfano MJ: Trimethoprim-sulfamethoxazole vs. ampicillin in the treatment of exacerbations of chronic bronchitis. *Ibid.*, pp. 19-20. 10. Medici TC: Trimethoprim-sulfamethoxazole (Bactrim™) in treating acute exacerbations of chronic bronchitis: summary of European clinical experience. *Ibid.*, pp. 13-14.

attacks *H. influenzae*—even
ampicillin-resistant strains



attacks *S. pneumoniae*



Economical b.i.d.

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole/Roche)

BactrimTM

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections. For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For antitoxin due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonia.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hemopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects. Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoproliferative thrombocytopenia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days

PNEUMOCYSTIS CARINII PNEUMONITIS

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose[®] packages of 100; Prescription Paks of 20 and 28. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500, Tel-E-Dose[®] packages of 100, Prescription Paks of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml), fruit-licorice flavored—bottles of 16 oz (1 pint).



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Reagan Proposes Changes In Health Funding

THE 1984 BUDGET recently unveiled by President Reagan calls for \$848.5 billion in government spending.

Of that total, the U.S. Department of Health and Human Services accounted for \$288.8 billion, the third largest budget in the world, after the United States and Soviet Union, according to a statement by department officials.

The overwhelming proportion of the HHS budget is slotted for the Social Security Administration at \$194.7 billion. Budgets of specific interest to medicine are the Public Service funds targeted at \$7.9 billion, and the Health Care Financing Administration budget of \$80.7 billion.

Changes in Medicare

Included in the HCFA budget are dramatic proposals to change the Medicare program. Among them:

- A prospective payment system for hospitals.
- Restructured coinsurance for hospitalized Medicare recipients.
- A voluntary voucher program that would allow Medicare recipients to enroll in prepaid health plans, such as health maintenance organizations (HMOs).
- A freeze on physician fees for one year, with no rules about assignment, meaning that physicians can accept Medicare reimbursements as payments in part and bill patients for the remainder.
- An increased premium charge for Part B coverage of physician fees, including an index for the deductible.

Other initiatives include a co-payment plan for Medicaid recipients calling for \$1 per outpatient visit and \$1 per hospital day for beneficiaries on welfare (\$1.50 and \$2 for beneficiaries not on welfare).

The budget also includes a proposal to limit the tax-free amount an employer can contribute to health benefits. The line would be drawn at \$175 per month for family coverage and \$70 per month for individual coverage.

If the proposals are accepted, they will hold the annual growth rate of the HHS budget to 5%, down from a high of 17% in fiscal year 1981.

The long-awaited consumer choice, or competi-

tive-model plan for health care, appears to have been shelved by the Reagan Administration. Instead of a comprehensive plan that would interconnect public and private payment systems for medical care, the Administration has offered a piecemeal approach that incorporates some of the competitive ideas, such as the voucher program and the tax limit on employer benefits contributions.

The most startling proposal relates to the co-payment provisions for Medicare recipients, both in the hospital plan and in the physician plan. Observers long have thought that government would not propose changes in the benefits packages, but these proposals look very much like such changes.

The Medicare catastrophic coverage proposal is billed in the budget as a provision of "unlimited hospital coverage of catastrophic illness for the first time."

Explaining the provision, HHS officials pointed out that "under current law the beneficiary hospitalized in 1984 for 150 consecutive days would owe \$13,475 from his or her own pocket.

"The beneficiary would also bear the full cost of all subsequent hospital days," they added.

"Under the new plan, the beneficiary's expenses would be \$1,530, with no coinsurance after 60 days."

Projected Savings

While the coverage looks greater, the fact is that the government expects to save \$663 million in fiscal 1984 by implementing the plan.

What it in effect will do is shift co-payment to the area of greater activity for Medicare hospitalization. Under the plan now in effect, recipients pay the full cost of hospitalization on the first day, but from the second to the 60th day there is no cost sharing. From the 61st to 90th day, the recipient share now would be \$87.50 per day, and \$175 per day from the 91st to the 150th day.

The new plan calls for the same full pay for the first day of hospitalization; about \$28 per day from the second to the 15th day; about \$17.50 per day from the 16th to 60th day; and catastrophic (no pay) coverage after the 60th day.

Explaining the budgetary savings, Robert J. Rubin, M.D. HHS Assistant Secretary for planning and evaluation, pointed out that the average hospital

stay for a Medicare recipient is 11.5 days. This will add \$280 from each recipient to the program, resulting in the projected savings, he said.

He added that only 200,000 of Medicare recipients, numbering some 29 million, ever stay more than 60 days during a given period.

DRGs

Additional savings will be realized by the prospective payment of hospitals based on 467 diagnosis-related groups (DRGs). This builds on the Medicare case management plan "associated with hospital reimbursement changes enacted in the Tax Equity and Fiscal Responsibility Act," officials said.

The projected freeze on physicians' reimbursement under Medicare is expected to save \$700 million, officials said. Dr. Rubin said that about half of the physicians in the country accepted assignment (Medicare reimbursements as payment in full). He added that there was nothing in the proposed rules to inhibit physicians from passing on fee increases to patients.

The budget proposals also anticipate gradual change in the premium and deductible for optional Medicare physician coverage under Part B of the program.

"When Medicare was established the premium was intended to cover 50 percent of Part B costs, but premiums now cover less than 25 percent of costs," officials said.

That percentage would move back up to 35 percent by 1988 if the new proposals are accepted, Dr. Rubin said. The per-month premium of \$12.20 will remain in effect until the end of the year.

In addition, the deductible will be indexed to keep pace with costs. That savings will amount to \$46 million in fiscal 1984. The premium proposals will result in \$359 million additional costs for fiscal 1984, but earn \$575 million in savings for the following fiscal year.

The increases in hospital co-payments, premium payments, and the prospect of additional billings from physicians who do not accept assignment probably will make enrollment in HMOs more attractive for Medicare recipients, Dr. Rubin said.

The new budget proposes to sweeten that possibility by increasing what the government will pay to "an amount equal to 95 percent of per-person costs of the Medicare program." Dr. Rubin pointed out that the government now pays only 80 percent.

"Medicare would remain the basic national health plan for the elderly, and alternative plans would

have to provide coverage at least equal to Medicare's," officials said.

"The voucher plan in essence invites private providers and insurers to 'outbid' Medicare if they can. The voucher program would be entirely voluntary, and beneficiaries could re-enter the Medicare system.

"In the case of low-priced alternative plans, cash rebates could be made to the beneficiaries."

Cap Tax-Free Benefits

The cap on tax-free health benefits would result in an addition of \$2.3 billion in income tax revenues in fiscal 1984, but that gain in revenue was not the main thrust of the proposal.

"The point here is that government will no longer subsidize medical care in that way," Dr. Rubin said.

The initial impact may be limited, since the average monthly health benefit is \$125, well below the proposed \$175 per month cutoff for family coverage.

"Currently, about 30 percent of those with employment-based health coverage receive employer contributions above these limits," officials said.

"While individuals and companies would remain free to purchase as much health coverage as they desire, the new provision would eliminate the bias that now works in favor of high-priced coverage and against comparable higher wages," they added.

In addition to the Medicaid co-payments proposals, which would add an estimated \$249 million in savings, the budget proposes maintaining reductions in the federal share of Medicaid.

"The plan would extend beyond fiscal 1984 the reduction in federal payments to states passed in the Omnibus Budget Reconciliation Act of 1981," officials said.

"The reduction would be cut, however, from 4.5 percent to 3 percent. The reduction will remain in place for an indefinite period, leaving in place the incentive for states to continue seeking new cost-saving Medicaid policies."

Officials said they expected to save \$524.9 million in fiscal 1985 by extending the reduction, adding that there would be no effect felt during 1984.

Other Cuts

Other HCFA cuts include a closing down of the professional standards review organizations regulatory effort. In the past three years, funding has gone from \$96 million to \$50 million to zero proposed for

(Continued on page 103)

Mississippi State Medical Association Auxiliary

A Celebration 1923-1983

The upcoming 60th Annual Session of the MSMA Auxiliary is a celebration — of the past six decades, the present, and the future. Plan to join us for the celebration!

Our general session and luncheon are set for Friday, May 13. Guest speaker will be Mrs. John Bates, president-elect of the AMA Auxiliary.

Several workshops are on the agenda, and they offer a variety of topics for discussion. There's something special planned for each day. "Through the Looking Glass: Images of a Medical Spouse" will be presented on Thursday, May 12 by Leonard Ball, M.D. Also on Thursday will be a film, "The Last Epidemic," sponsored by the Physicians for Social Responsibility. The film provides a focus on the ramifications of a nuclear war. Friday's schedule includes a focus on DUI legislation in a joint meeting with the MSMA Section on Preventive Medicine. Dr. Morris Chafetz, member of the Presidential Commission on Drunk Driving, will speak on "New Approaches to Prevention." Saturday's schedule includes a presentation by Sandy Lemon. "Color Me Beautiful" will show how to enhance natural beauty by wearing colors that make you look great and feel fabulous.

The Boutique Booth will feature a collection of hand-made articles and crafts for sale, with proceeds going to the AMA-ERF. A new feature this year will be a raffle item — a counted cross-stitch-on-damask tray.

Throughout the convention enjoy coffee, soft drinks and an array of delectable treats at the Hospitality Center, located in the Main Lobby of the Royal d'Iberville and provided complimentary by the MSMA and the MSMA Auxiliary.





The President Speaking

Potpourri

SIDNEY O. GRAVES, JR., M.D.
Natchez, Mississippi

The 115th Annual Session of the MSMA is scheduled for May 11-15, 1983. As I have said on several occasions before, many proposed changes are to be presented to the House of Delegates. You owe it to yourself to be familiar with these changes so you can give an informed opinion to your delegates. Better still, come to the meeting and watch how your organization functions.

* * *

The seminar on "Health Issues in the 80's" was held on March 5 and this was followed with a Political Action Workshop on March 6. The weekend was a success. We had about twice as many at the Saturday session as we had at a similar meeting last year. The talks were outstanding, but the information was very depressing. Every practicing physician in the state should have heard what is staring us in the face. We are all in trouble, and we need to inform ourselves and participate in the decisions affecting our profession. The decisions are being made either with or without us.

* * *

The legislature passed a bill which would exempt certain graduates of foreign medical schools from a five-year limitation on their license at state supported institutions. The Board of Trustees of your association voted unanimously to oppose this legislation. In a letter to the governor asking him to veto this bill, it was pointed out that there are two reasons for our request. One is that the legislature is assuming authority that has been vested in the Board of Medical Licensure for monitoring certain standards for the practice of medicine. Second, it is suggested that the legislature's action tends to encourage an inferior quality of medical care in these institutions. It was asked rhetorically if the state would consider allowing persons who have failed the Bar Examination to practice in the Attorney General's office. The governor did not veto the bill.

* * *

In this column several months ago, I spoke of the effort of the Joint Commission on Accreditation of Hospitals to abandon the Medical Staff and replace it with the so-called Organized Staff. This staff could be composed of chiropractors, nurse practitioners, psychologists, and podiatrists. It is not unlikely that in some hospitals these non-physician practitioners could be the majority of the staff and the medical doctors would be the minority. Perhaps the saddest part of this historic change is that it has taken place with little discussion among rank and file physicians, and virtually no discussion in the general community among citizens who are today's and tomorrow's patients.

* * *

Good News!! The Council on Budget and Finance recommended that there *not* be an increase in the MSMA dues for this year.

* * *

Mark Russell will be the entertainment at the MSMA party on Friday, May 13, during the Annual Session. Mark is *the* premier talent we have been able to secure for our annual membership banquet. He is a political satirist and very good at his job. Plan to attend!!

★★★

Chemical Ototoxicity

Ototoxicity has been recognized as a side effect of many drugs and chemicals. The clinical manifestations of ototoxicity are tinnitus, hearing loss, vertigo and a fullness in the ears. Many drugs in use today predominantly affect either the cochlear or vestibular portion of the inner ear.

Tinnitus always accompanies an acquired neurosensory hearing loss but may occur as the only complaint following use of ototoxic drugs. The degree of tinnitus varies widely depending upon the causative agent. Mandelamine, quinine, and salicylates in low to moderate doses generally produce mild and sometimes reversible tinnitus. Tinnitus caused by the "loop" diuretics is sudden in onset, extremely severe, and usually accompanied by some loss of hearing.

Ototoxic hearing loss also varies, depending upon the drug causing the problem. Deafness is generally always sensorineural in character and the first sign of impairment is an inability to understand speech and an increase in the volume of the patient's own voice as he has difficulty hearing himself. Initially the hearing loss may be masked by tinnitus and not noted until extremely severe. The permanency of ototoxic deafness depends upon drug dosage, length of treatment, prior therapy, and individual sensitivity. Symptoms of deafness may occur by the fourth day of therapy with potent drugs like the aminoglycoside group of antibiotics and some of the chemotherapy agents, or may appear several weeks after completion of therapy.

If possible, pretreatment base line pure tone audiometric studies should be obtained prior to therapy. These may be obtained during the first three days of therapy and portable audiometric studies are adequate.

Damage to the vestibular system causes vertigo and this is commonly associated with the use of gentamycin, streptomycin and minocycline. Although vertigo may occur following a single dose of an ototoxic drug, its severity is usually directly

proportional to the duration and dose of the drug. Onset of vertigo is usually insidious but progresses to a severe disabling state if therapy is continued.

All of the aminoglycosides, vancomycin, minocycline, potent "loop" diuretics (furosemide, ethacrinic acid), aspirin, quinine and the angioplastic agents are severe offenders. Any use of these drugs should be carefully monitored and the need of them weighed against the potential side effects. All patients should be informed of possible side effects prior to institution of therapy, advised of the symptoms and urged to report any changes immediately. If possible, the drug should be immediately discontinued.

MYRON W. LOCKEY, M.D.
Associate Editor

Changes in Health Funding

(Continued from page 100)

fiscal 1984. Also shut down was the end-stage renal disease councils program previously budgeted at \$5 million.

Proposed budgeting for the National Institutes of Health was increased by \$73 million to \$4.077 billion in fiscal 1984, and budgets for the Alcohol, Drug Abuse, and Mental Health Administration was increased by a modest \$1 million to \$421 million.

In for severe paring was the Health Resources and Services Administration, whose budget was cut from \$1.207 billion in fiscal 1983 to \$977 million in 1984.

Totally eliminated from that budget was the health planning program, previously budgeted at \$58 million, and drastically cut by \$56 million was the health professions education program, now budgeted at \$116 million.

Also cut within the Health Resources and Services Administration was the Indian Health Service, down \$7 million from \$660 million in fiscal 1983 to \$653 million in fiscal 1984.

Presenting Mark Russell . . .



Enjoy the humor of Mark Russell!!

The popular political satirist will be the feature entertainment at the annual MSMA/MSMA Auxiliary membership banquet. The event will be Friday, May 13, at the Royal d'Iberville Hotel in Biloxi.

115th Annual Session

Mississippi State Medical Association
May 11-15, 1983
Biloxi

The upcoming 115th Annual Session of the Mississippi State Medical Association inaugurates the new Wednesday-Sunday format which was mandated by the House of Delegates in 1981. Although the meeting is one day shorter than usual, the agenda contains all of the attractions of past meetings, and the schedule has been arranged to provide for a free afternoon to enjoy the activities of the sunny Gulf Coast.

House of Delegates

Sessions of the House of Delegates are scheduled for Thursday, May 12 and Sunday, May 15. Both meetings will begin at 9:00 a.m. Dr. William Y. Rial, president of the American Medical Association, will address the opening session. Delegates will also hear an address by Dr. Sidney O. Graves of Natchez, MSMA president. The inauguration of Dr. Whitman B. Johnson of Clarksdale as 1983-84 president will take place during the final session.

Delegates will cast ballots for more than 80 nominees who have been selected by the Nominating Committee to fill 36 vacancies in association offices. A list of candidates was mailed to all members 60 days prior to the elections, in accordance with the association's bylaws. The list of candidates also appears elsewhere in this issue of JOURNAL MSMA.

Scientific Assembly

Continuing medical education credit will be awarded for the scientific assembly, which begins on Friday, May 13. The 14 scientific sections have scheduled programs on Friday and Saturday. Two medical specialty organizations, the American College of Surgeons and the Mississippi Society of Gastroenterology, have also arranged educational programs. The complete program for the scientific assembly is printed in this issue of JOURNAL MSMA, pages 106-107.

Concurrent Meetings

Among the many medical related groups which have scheduled meetings in conjunction with the

annual session are the Mississippi Foundation for Medical Care and the Medical Assurance Company of Mississippi (MACM).

Special Events

The annual tennis and golf tournaments and the fishing rodeo are again on the schedule. Entertainer Mark Russell will highlight the annual membership banquet on Friday night. The president's reception and an MMPAC reception are on the calendar of events for Wednesday and Saturday nights, and medical alumni activities are planned for Thursday night.

OFFICIAL CALL

To all members of the Mississippi
State Medical Association:

The 115th Annual Session of the Mississippi State Medical Association is called to meet at Biloxi, Mississippi, on Wednesday, May 11, 1983, pursuant to Article V of the Constitution. The House of Delegates will be convened at the Royal d'Iberville at 9:00 a.m. on May 12.

The Scientific Assembly, consisting of the 14 Scientific Sections, will meet during May 13-14, 1983.

No member or guest will be permitted to participate in any aspect of the annual session until regularly registered.

SIDNEY O. GRAVES, M.D.
President

J. ELMER NIX, M.D.
Secretary-Treasurer

SCIENTIFIC PROGRAM

115th Annual Session

FRIDAY, MAY 13, 1983

9:00 a.m. MSMA Section on Medicine

Sexually Transmitted Diseases and Related Syndromes (William A. Causey, M.D., Jackson, MS)

Infectious Diarrhea: Evaluation and Management (Eric A. McVey, M.D., Jackson, MS)

The "New" Pneumonias (Max Taylor, M.D., Jackson, MS)

Newer B-lactam Antibiotics (Dr. McVey)

Antifungal and Antiviral Chemotherapy (Dr. Causey)

9:00 a.m. MSMA Section on Family Practice

Management of Rheumatoid/Osteoarthritis with Emphasis on the Newer Non-Steroidal Anti-Inflammatory Agents (Jacques Caldwell, M.D., Gainesville, FL)

Update on Antibiotics (Charles Sanders, M.D., New Orleans, LA)

Hypokalemia: Its Prevalence, Its Risks, and Appropriate Control (Richard Solomon, M.D., Providence, RI)

Late Effects of Nutrition, Obesity and Hypertension (John Silverin, Philadelphia, PA)

9:00 a.m. MSMA Section on Surgery

Current Concepts in Management of Pancreatic Cancer (John Beal, M.D., Chicago, IL)

Surgery of Extra-Cranial Cerebral and Arterial Insufficiency (Frank E. Schmidt, M.D., New Orleans, LA)

Effects of Location on Wound Tensile Strength (Keith Smith, M.D., Jackson, MS)

1:15 p.m. MSMA Section on Preventive Medicine

War Against Drunk Driving . . . A Legislator's View (Sen. Martin T. Smith, Poplarville, MS)

The Presidential Commission on Drunk Driving: New Approaches to Prevention (Morris Edward Chafetz, M.D., Washington, DC)

Tuberculosis in Mississippi Today: "White Plague" (Resistance) on the Rise (Donald Williamson, M.D., Jackson, MS)

1:30 p.m. American College of Surgeons

Management of Thyroid Nodules (John Beal, M.D., Chicago, IL)

Arterial Emboli from Atherosclerotic Lesions (Frank E. Schmidt, M.D., New Orleans, LA)

Ten Year Experience with Total Hip Arthroplasty (George D. Purvis, M.D., Jackson, MS)

1:30 p.m. MSMA Section on Ob-Gyn

Urinary Stress Incontinence — Introduction (Fred Ingram, M.D., Jackson, MS)

New Approach to Urinary Stress Incontinence — Paravaginal Suspension (George Ball, M.D., Jackson, MS)

Recurrent Urinary Stress Incontinence — Modified MMK (Winfred Wiser, M.D., Jackson, MS)

1:30 p.m. MSMA Section on Pediatrics

Epstein-Barr Virus: Diagnosis and Management (Irwin Cohen, M.D., New Orleans, LA)

Diagnosis and Management of Recurrent Urinary Tract Infections (Dr. Cohen)

SATURDAY, MAY 14

8:00 a.m. MSMA Section on Radiology

Unusual Epigastric Air Collections in Infants (Arvin E. Robinson, M.D., Mobile, AL)

Hepatobiliary Imaging by New Mo-

- dalities* (Robert L. Dubuisson, M.D., Mobile, AL)
Ultrasonography of the Gallbladder and Biliary Ducts (John Gibson, M.D., Jackson, MS)
Nuclear Magnetic Resonance (Joseph G. Vacea, Ph.D., Milwaukee, WI)
- 9:00 a.m. **Mississippi Society of Gastroenterology**
Chest Pain — Cardiac or Esophageal? (Thomas D. Crowson, M.D., Meridian, MS)
Colorectal Carcinoma — Screening (Who and How) (William M. McKell, Jr., M.D., Jackson, MS)
Ostomies — What's New? (William O. Barnett, M.D., Jackson, MS)
Pediatric Diarrhea (Paul H. Parker, M.D., Jackson, MS)
- 9:00 a.m. **MSMA Section on Anesthesiology**
Pathophysiology of Alcoholism and Other Drug Addictions (Doyle P. Smith, M.D., Jackson, MS)
Anesthesia: An Occupational Hazard (William J. Farley, M.D., Atlanta, GA)
Pharmacokinetics and Comparison of Morphine Sulphate Sublimase and Sufentanyl in Cardiac Anesthesia (Carl Rosow, M.D., Boston, MA)
- 9:00 a.m. **MSMA Section on Orthopedic Surgery**
Fractures of Shaft of Radius and Ulna in Adults (Lewis D. Anderson, M.D., Mobile, AL)
Recognition of Fractures of Cervical Spine (Dr. Anderson)
- 9:00 a.m. **MSMA Section on Urology**
What's New in Male Infertility (Ronald W. Lewis, M.D., Covington, LA)
- 9:00 a.m. **MSMA Section on Pathology**
Utility of Fine Needle Aspiration Cytology (William T. Mitchell, Jr., M.D., New Orleans, LA)
Histopathology of Endometrial Biopsy (Dr. Mitchell)
- 9:00 a.m. **MSMA Section on Psychiatry**
Anxiety: The Therapeutic Dilemma (Francois E. Alouf, M.D., Chicago, IL)
- 9:00 a.m. **MSMA Section on Dermatology**
Therapeutic Update (Larry E. Millikan, M.D., New Orleans, LA)
- 9:00 a.m. **MSMA Section on EENT**
Ocular Plastic Surgery (David Segrest, M.D., Jackson, MS)
Facial Plastic Surgery (Calvin Johnson, M.D., New Orleans, LA)

James Grant Thompson Memorial Lecture

by

John M. Beal, M.D., President
American College of Surgeons

Friday, May 13, 1983

MEDICAL ORGANIZATION

AMA President Will Address MSMA House of Delegates



William Y. Rial, M.D., of Swarthmore, Pennsylvania, president of the American Medical Association, will address the opening session of the House of Delegates on Thursday, May 12.

Tennis, Golf, Fishing Events On Annual Session Calendar

Registration is underway for MSMA's annual tennis tournament, golf tournament, and deep sea fishing rodeo. All three events are on the schedule of activities for the 115th Annual Session in Biloxi.

The tennis tournament, sponsored by the Medical Assurance Company of Mississippi is set for Saturday, May 14, at the Hiller Park Courts. Matches will begin at noon. Trophies will be awarded for winners and runners-up in men's and women's doubles.

The golf tournament will get underway at 11:00 a.m. on Friday, May 13 at the Sunkist Course. Trophies and prizes will be presented to winners in several categories of competition.

Two of the Gulf Coast's finest charter boats have been reserved for the fishing rodeo, set for Friday and Saturday, May 13 and 14. Boats will leave from the Broadwater Marina at 7:00 a.m. and return at 3:30 p.m. The \$65.00 registration fee covers boat rental for the day, soft drinks and sandwiches.

Registration forms were mailed to members with the regular MSMA "Blue Sheet." For additional information, please call the headquarters office.

Elections Will Highlight House of Delegates Session

Delegates to MSMA's 115th Annual Session will cast ballots for more than 80 nominees who have been selected by the Nominating Committee to fill 36 vacancies in association offices. Elections will be held during the Sunday, May 15 session of the House of Delegates.

The list of nominees was published and distributed to the membership last month, 60 days in advance of the elections, in accordance with requirements by the association's constitution and bylaws.

Thirteen officer and board of trustees posts are included in the vacancies, along with a number of council positions. The election will also determine the list of nominees to be submitted to the Governor for consideration for appointment to the Mississippi State Board of Medical Licensure.

Candidates for the post of president-elect are Drs. Charles R. Jenkins of Laurel and Ellis M. Moffitt of Jackson.

Nominees for vice president are: Drs. Hugh A. Gamble, III, of Greenville, Thomas S. Glasgow of Oxford and Lee H. Rogers of Tupelo (North District); Drs. Guy R. Braswell of Grenada, Barry W. Holcomb of Vicksburg and Stanley A. Wade, Jr. of Meridian (Central District); and Drs. Ralph H. Brock of McComb, Robert E. Carter, Jr. of Biloxi, and Mal G. Morgan of Natchez (South District).

Two AMA delegate positions will be decided, and nominees are: Drs. J. Ed Hill of Hollandale and Stanley A. Wade, Jr. of Meridian (for the term expiring December 31, 1985) and Drs. Gerald P. Gable of Hattiesburg and Sidney O. Graves, Jr. of Natchez (term expiring December 31, 1984).

Nominated for alternate delegate to the AMA are Drs. William C. Gates of Columbus and Stanley A. Hill of Corinth (for the term expiring December 31, 1985) and Drs. Carl G. Evers of Jackson and James C. Waites of Laurel (term expiring December 31, 1984).

Two JOURNAL MSMA positions will be included in the election. Candidates for editor are Drs. Joe S. Covington of Meridian and Myron W. Lockett of Jackson. Nominated for associate editor are Drs. M. Beckett Howorth, Jr. of Oxford, Joseph E. Johnston of Mt. Olive, and Richard C. Miller of Jackson.

Nominees for board of trustees are: Drs. Stanley Hartness of Kosciusko, W. Bernard Hunt of Grenada and Edward Pennington of Ackerman (District 4); Drs. George Ball of Jackson, Tom H. Mitchell of Vicksburg, and C. G. Sutherland of Jackson (District 5); and Drs. George L. Arrington, Jr. of Meridian and Richard F. Riley of Meridian (District 6).

The Nominating Committee selected Drs. Michael P. Brooks of Laurel, W. Joseph Burnett of Oxford and Richard H. Russell of New Albany as nominees for the vacancy on the Council on Budget and Finance, and named Drs. Michael H. Carter, Jr. of Greenwood, David L. Clippinger of Gulfport and Max L. Pharr of Jackson as candidates for the position on the Council on Constitution and Bylaws.

Election results will determine three posts on the Judicial Council. Nominees are: Drs. L. Stacy Davidson, Jr. of Cleveland, George C. Furr of Clarksdale and Eugene F. Webb of Itta Bena (District 1); Drs. Tommy T. Simpson of Ripley and William A. Spencer of Sardis (District 2); and Drs. Charles D. Miles of Columbus and Earl F. Whitwell of Tupelo (District 3).

Nominees for the Council on Legislation are: Drs. Edwin G. Egger of Greenville and Edwin M. Hemness of Clarksdale (District 1), Drs. Thomas S. Glasgow of Oxford and Ralph D. Ford of Ripley (District 2), and Drs. Lee H. Rogers of Tupelo and Ray Lyle of Starkville (District 3).

Other council vacancies and nominees include: Council on Medical Education — Drs. Mike C. Campbell, Jr. of Grenada, L. C. Henson of Kil-michael and Charles A. Osborne of Eupora (District 4), Drs. Guy D. Campbell and Doyle P. Smith, both of Jackson (District 5), and Drs. Joe S. Covington and Charles L. Wilkinson, both of Meridian (District 6); and Council on Medical Service — Drs. S. Lamar Bailey of Kosciusko, Samuel B. Caruthers of Grenada and Stanley Hartness of Kosciusko (District 4), Drs. S. Patrick Barrett, Bernard H. Booth and C. David Scruggs, all of Jackson (District 5) and Drs. Oliver W. Byrd of Quitman, Charles N. Cren-

shaw, Jr., of Newton and Prentiss F. Keyes of De-Kalb (District 6).

Nominees to be submitted to the Governor for vacancies on the Board of Medical Licensure will be elected from the following candidates: Drs. Helen B. Barnes of Jackson; Joe S. Covington of Meridian; D. E. Magee, Jr., of Jackson; Martin H. McMullan of Jackson; Walter H. Rose of Indianola; Jeanette Pullen of Jackson; Larry H. Day of Hattiesburg; James C. Funderburg of Natchez; Dewey H. Lane, Jr. of Pascagoula; Andrew K. Martinolich of Bay St. Louis; Gilbert R. Mason of Biloxi; James S. Poole of Gloster; Charles R. Jenkins of Laurel; Victor E. Landry of Lucedale; Paul H. Moore, Sr., of Pascagoula; David M. Owen of Hattiesburg; Katherine A. Pyron of Gulfport; and C. D. Taylor, Jr., of Pass Christian.

Annual Session Schedule Includes Alumni Activities

Medical alumni associations from the University of Tennessee, Tulane, and Ole Miss have scheduled activities during MSMA's 115th Annual Session.

The University of Tennessee Alumni Association will host a reception for alumni and friends on Thursday evening at the Royal d'Iberville Hotel.

Tulane medical alumni will be entertained with a reception on Thursday evening at the home of Dr. Tom E. Benefield, Jr., president of the Tulane Medical Alumni Association.

The annual party for Ole Miss medical alumni is set for Thursday evening at 7:00 at the Versailles Room of the Royal d'Iberville Hotel. The Past Presidents Council will meet for breakfast on Thursday morning, and the annual business meeting of the Medical Alumni Chapter will be conducted on Friday morning.

MMPAC Reception

Saturday, May 14

5:30 p.m.

Royal d'Iberville Hotel

Biloxi, MS

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Mississippi offices in this election year.**

MSMA Seminar Examines Health Care Issues

By the end of this decade there will be some 536,000 practicing physicians in the United States, an increase of 43% in only 12 years.

This projected oversupply could dramatically alter the practice of medicine, affecting even that element which is of paramount importance, the doctor-patient relationship. That was the prediction of Dr. Alvin Tarlov, one of the speakers at MSMA's two-day conference on health issues last month.

The conference agenda featured a dozen speakers who addressed a number of critical issues including the impending doctor glut, health care cost containment measures, and effects of medical technology. The seminar also examined the state and congressional legislation outlook and concluded with a political action workshop.

The panelists generally acknowledged that the practice of medicine is undergoing a period of profound change. Discussion of the ramifications of that change was the overall theme of the conference.

According to Dr. Tarlov, former chairman of Graduate Medical Education National Advisory Committee (GMENAC), three powerful factors will produce the most radical changes. These factors are the evolution and recognition of new objectives, the

progressive industrialization and corporate structuring of medical practice, and the increase in the number of practicing physicians.

Society's expectations of medicine have changed from the past emphasis on prevention of death from epidemic diseases to the present demand for correction of physiological aberrations, said Dr. Tarlov. And medical practice in the new era beginning about 1990 will face a new societal expectation — the maintenance and improvement of patient functioning in everyday life.

This growth in technology has produced an emotional distance between the doctor and the patient, and that distance has been widened by such factors as the third-party payment system and the corporate structuring of medical practice. Dr. Tarlov sees evidence of an industrialization of medicine which has already taken place and which will probably grow. However, the realization of this industrialization cannot take place without the physician's willingness to give up some control, he reminded. He pointed to a declining interest on the part of many young physicians for the traditional small practice and an increasing pursuit of "fast start-up" and protection from economic insecurity. He remarked that in many instances the profession has taken on a "labor-management mentality."

Providing the final impetus for the industrializa-



MSMA President Dr. Sidney O. Graves introduced members of the seminar panel. Seated, from left, are Dr. John J. Ring, chairman of the AMA Council on Medical Service; Dr. Alvin Tarlov, former chairman of the Graduate Medical Education National Advisory Committee (GMENAC); and Dr. Franklin B. Ott of Fort Lauderdale, Florida.



"The problems we face are the problems of success," said luncheon speaker Harry Schwartz, Ph.D., senior writer for Private Practice magazine. Dr. Swartz presented an entertaining and informative address on what he terms the "real villain" — progress in medical technology.

tion of medicine will be the projected increase in physician numbers. The effects are already being seen, according to Dr. Tarlov. He noted that more physicians are looking at salaried practices with more favor, to the extent that 50% now derive some income from salary. Along with the increase in numbers will come elaborate sets of rules and guidelines for utilization for cost control purposes, and much of this rule-making is already in effect, he reminded.

In view of these profound changes, emphasis on the doctor-patient relationship should be of foremost importance. The essence of that relationship, Dr. Tarlov concluded, is concern for the patient's interest beyond all consideration of personal gain by the physician.

The topic of the physician-patient relationship reappeared during spirited question and answer sessions which followed each panelist's address.

Other speakers during the morning session included John J. Ring, M.D., chairman of the AMA Council on Medical Service, who spoke on "Third Party Reimbursement — The Future Scene"; Franklin B. Ott, M.D., of Fort Lauderdale, Florida, who discussed "Individual Option Plans — How and Why They Work"; and Floyd Smith, South Central Bell executive from Birmingham, who presented "A Health Care Coalition — It's Working in Birmingham."



Carla Neuschel, assistant director of the AMA's Washington office, described measures under consideration by Congress.



Dr. James O. Manning, center, chairman of MMPAC, presided at the political action workshop which featured Russ Brady, left, of Chicago and Mrs. Connie Moore of West Palm Beach, Florida, representatives of AMPAC.

MSMA CONFERENCE / Continued

"The problems we face are the problems of success," said luncheon speaker Harry Schwartz, Ph.D., senior writer for *Private Practice Magazine*. He emphasized his statement with humorous and insightful comments about the "real villain" in the situation, medical technology and its resulting costs. The villain gained strength, he said, back in the days of Lyndon Johnson when the belief was circulated that there was, indeed, a "free lunch," and that free lunch was to be health care. He recited what he termed "Schwartz's transcription of Powell's law," which declares that the potential for free medical care is infinite. When there is infinite demand facing finite resources, a rationing situation develops, he noted, asking the question, "Who is to decide?" The problems that future technology may bring are almost unimaginable, suggesting even the day of the "prophylactic heart." He summarized his discussion of problems brought about by success in medical research by declaring that "in health care the greatest economy is death."

During the afternoon focus on legislation, Carla Neuschel, assistant director of AMA's Washington



Dr. Ellis Moffitt, chairman of the MSMA Board of Trustees, is the newest member of the MSMA Auxiliary. During a break in the seminar's activities, he posed with his wife, Dr. Nina B. Goss Moffitt, at right, and Auxiliary membership chairman Mrs. Ted Blanton.



A number of MSMA Auxiliary members registered for the seminar. On hand to welcome them were Mrs. James Martin, right, 1982-83 president, and Mrs. Stanley Hartness, president-elect.

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office, provided a detailed summation of probable legislative action. Conference registrants then heard a description of the Mississippi legislative outlook by Sen. Bob Montgomery of Canton.

Concluding the first day was a discussion of politics in Mississippi, led by John Quincy Adams, Ph.D., of Millsaps College, and Wilson F. Minor, syndicated columnist.

Congressman Webb Franklin of Greenwood was luncheon speaker during the second day of the conference. He provided his impressions of the attitude in Washington regarding health care legislation, particularly in regard to congressional concerns about increasing health care costs and proposals to restrain such costs.

Representatives of the American Medical Political Action Committee presented a three-hour political action workshop to conclude the seminar.

NEW MEMBERS

ANAND, VINOD K., Jackson. Born India, July 20, 1952; M.D., Maulana Azad Medical College, Delhi University, New Delhi, India, 1974; interned Irwin Hospital, New Delhi, one year and surgery residency one year; surgery residency, Misericordia Hospital, New York City, 1976-78; otolaryngology residency, Manhattan Eye, Ear, Throat Hospital, New York City, 1976-81; elected by Central Medical Society.

BOGGESE, JOSEPH S., Columbus. Born Columbus, MS, Sept. 5, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned City of Memphis Hospital, Memphis, one year; otolaryngology residency, University of Alabama Hospital, Tuscaloosa, 1978-82; general surgery residency, Carraway Methodist Hospital, Birmingham, 1979-80; elected by Prairie Medical Society.

BURNETT, DAVID WILLIAM, Purvis. Born Van Wert, OH, June 16, 1946; D.O., Kirksville College of Osteopathic Medicine, Kirksville, MO, 1979; interned Phoenix General Hospital, Phoenix, AZ, 1979-80; elected by South Mississippi Medical Society.

CAMERON, O. W., JR., Meridian. Born Meridian, MS, Nov. 10, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned University of Louisville Hospitals, Louisville, KY, one year; orthopedic surgery residency, Georgia Baptist Hospital and Scottish Rite Hospital, Atlanta, 1978-82; hand surgery and sports medicine fellowship, University of Virginia, July-December, 1982; elected by East Mississippi Medical Society.

CANNON, CHARLES NEIL, Philadelphia. Born Philadelphia, MS, June 12, 1923; M.D., University of Mississippi School of Medicine, Jackson, 1961; interned Duval County Medical Center, Jacksonville, FL, one year; surgery residency, same, 1962-64; elected by East Mississippi Medical Society.

CARTER, THAD C., Gulfport. Born Holden, LA, Dec. 9, 1941; M.D., Louisiana State University School of Medicine, New Orleans, 1968; interned Charity Hospital, New Orleans, one year; urology residency, same, 1969-73; elected by Coast Counties Medical Society.

CHASE, DAVID G., Booneville. Born Booneville,

MS, Sept. 27, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned University Medical Center, Jackson, one year; internal medicine residency and pulmonary fellowship, same, 1978-82; elected by Northeast Mississippi Medical Society.

CLARKSON, JAMES E., Biloxi. Born Selma, AL, July 30, 1945; M.D., University of Cincinnati College of Medicine, Cincinnati, OH, 1971; interned University of Iowa Hospitals, one year; internal medicine residency, USAF, 1974-76; medical oncology fellowship, USAF, 1977-79; elected by Coast Counties Medical Society.

COMBEST, FELTON E., JR., Greenville. Born Greenville, MS, Dec. 20, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned and pediatric residency, University Medical Center, Jackson, 1978-82; elected by Delta Medical Society.

COWART, MARY ANN, Meridian. Born Jackson, MS, June 24, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and diagnostic radiology residency, University Medical Center, Jackson, 1976-80; ultrasound and CT fellowship, Shands Teaching Hospital, University of Florida, Gainesville, 1980-81; elected by East Mississippi Medical Society.

CROCKER, ROBERT L., Brandon. Born Cleveland, MS, April 10, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and family practice residency, University of Tennessee, Chattanooga, 1979-82; elected by Central Medical Society.

FRASER, BLAIR F., Water Valley. Born Canada, June 22, 1946; M.D., Dalhousie University, Halifax, N.S., Canada, 1976; interned Halifax, N.S., Canada, one year; elected by North Mississippi Medical Society.

JACKSON, PAUL D., Greenville. Born Greenville, MS, April 27, 1951; M.D., Wayne State University School of Medicine, Detroit, MI, 1978; interned and ob-gyn residency, Saint Joseph Mercy Hospital, Pontiac, MI, 1978-82; elected by Delta Medical Society.

MARTIN, RAYMOND S., III, Jackson. Born Nashville, TN, March 3, 1950; M.D., Johns Hopkins University School of Medicine, Baltimore, MD, 1976; interned Massachusetts General Hospital, Boston, one year; surgery residency, same, 1977-82; elected by Central Medical Society.

NEW MEMBERS / Continued

NOORANI, PAYAR ALI, Greenville. Born Delhi, India, June 5, 1940; M.D., Liaquat Medical College, India, 1966; interned and neurology residency, University Medical Center, Jackson, MS, 1977-82; elected by Delta Medical Society.

SONGCHAROEN, SUTHIN, Jackson. Born Nan, Thailand, July 22, 1941; M.D., University of Medical Sciences, Thailand, 1966; interned University Medical Sciences, Thailand, and Grace Hospital, Detroit, MI, 1966-68; medicine residency, Grace Hospital, 1968-70; residency medicine, Mercy Hospital, Baltimore, MD, 1970-71; rheumatology fellowship, University of Maryland, Baltimore, 1971-72; elected by Central Medical Society.

VALENTINE, JAMES L., Belzoni. Born Newton, MS, May 9, 1953; D.O., University of Health Sciences College of Osteopathic Medicine, Kansas City, MO, 1981; interned Sun Coast Hospital, Largo, FL, one year; elected by Delta Medical Society.

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PERSONALS

ROBERT B. BRAHAN has associated with The Hattiesburg Clinic, P.A. for the practice of internal medicine.

ROBERT T. CATES of Ridgeland has been recertified by the American Board of Family Practice.

DAVID G. CHASE announces the opening of his office for the practice of pulmonary medicine in Booneville.

CARL EVERS of UMC was guest speaker for an Alpha Epsilon Delta banquet in Oxford.

THOMAS GANDY of Natchez received the Natchez Historical Society's Historic Preservation Award recently, in recognition of his work in cataloging, restoring and preserving historic photographs of the city.

CLYDE HAGOOD of Biloxi was named chief of staff for Gulf Coast Community Hospital.

JAMES HARDY of UMC recently visited the Middlesex Hospital-Medical School of Hammersmith Hospital-Medical School in London and attended a meeting in Basle of the Executive Committee, International Society of Surgery, as editor of *World Journal of Surgery*.

M. BECKETT HOWORTH of UMC is the author of a self-help book, *Cure Your Own Backache*, published recently by University Press of Mississippi.

JOSEPH E. JOHNSTON of Mount Olive has been appointed to the Commission on Education of the American Academy of Family Physicians.

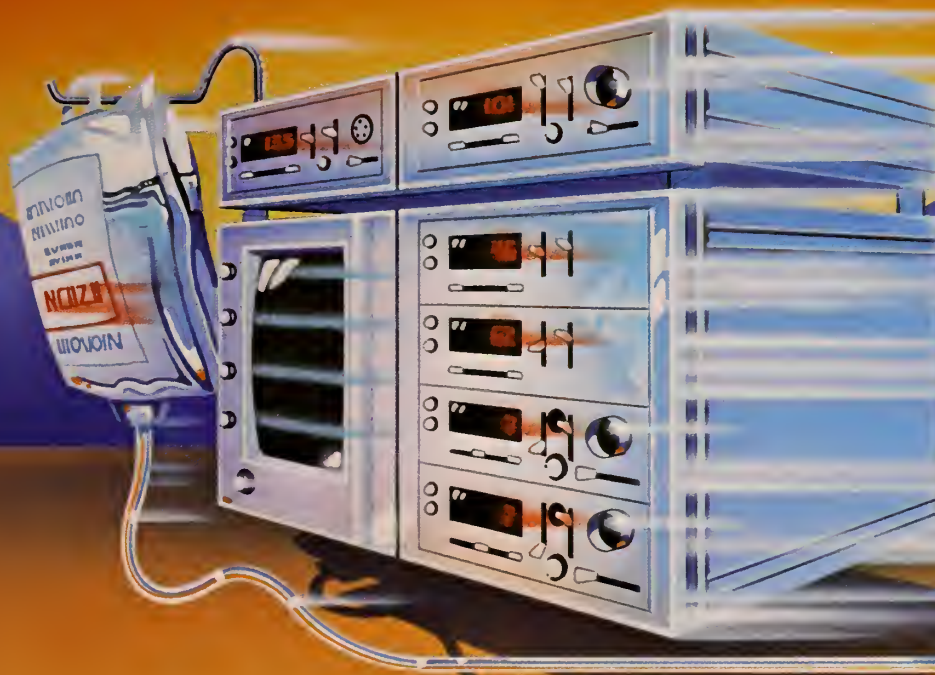
MANDE D. MONTA announces the opening of offices for the practice of internal medicine in Meadville and Roxie.

WILLIAM C. NICHOLAS of UMC recently spoke on diabetes at meetings of the Jackson Central Lions Club and the Vicksburg and Washington County chapters of the American Diabetes Association, and presented a paper at the annual meeting of the Southern Sugar Club at Kiawah Island, South Carolina.

BENELLA OLTREMARI of Greenville announces the association of PATRICIA PAYNE for the practice of pathology.

OMAR SIMMONS of Newton was recently honored by the Board of Directors, Rush Hospital/Newton, for his many years of service to the hospital.

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POSTGRADUATE CALENDAR

April 15-16

BASIC MANAGEMENT OF THE SPINAL CORD INJURY PATIENT

University Medical Center and Mississippi Methodist Hospital and Rehabilitation Center, Jackson

Sponsored by the University of Mississippi School of Nursing, the Methodist Hospital and Rehabilitation Center and the UMC Division of Continuing Health Professional Education.

Coordinators: Patsy H. Carroll, R.N., M.N., assistant professor of nursing, and Jan M. Evers, R.N., M.N., assistant professor of nursing and associate dean for continuing education in nursing. Course coordinator for the Mississippi Methodist Hospital and Rehabilitation Center is Dr. Michael Vise, chief of the Spinal Injury Service.

Lectures, discussions, films, and workshops will be used to instruct registrants on dealing with all aspects of physical and adjustment problems in the spinal cord injury patient. Fee: \$50. Credit: 11.3 hours AMA Category I.

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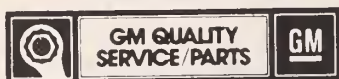
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April 16

COLORECTAL CANCER

University of Mississippi Medical Center, Jackson

Sponsored by the Office of Continuing Medical Education Memorial Sloan-Kettering Cancer Center and the UMC Division of Continuing Health Professional Education.

This program is part of the Visiting Faculty Program, a nationwide accredited, two-year CME course sponsored by Memorial Sloan-Kettering Cancer Center. Emphasis is on evaluation of risk factors, early detection, diagnosis, management and follow-up of colorectal cancer. Fee: \$10. Credit: 6 hours AMA Category I, American Academy of Family Physicians, and American Osteopathic Association Category 2-B and 6 cognates, Formal Learning, of The American College of Obstetricians and Gynecologists.

April 22

SLEEP DISORDERS MEDICINE

University Medical Center, Jackson

Sponsored by the UMC Department of Psychiatry and Human Behavior, Division of Somnology, School of Nursing and Division of Continuing Health Professional Education.

Coordinator: Dr. Milton Kramer, professor of psychiatry and human behavior and director, Division of Somnology.

This program is a review of prevalent sleep disorders, including narcolepsy and sleep apnea, impotence, wake sleep rhythm, insomnias, and the use and abuse of sleeping pills. Fee \$65. Credit: 4.5 hours AMA Category I and American Academy of Family Physicians.

April 30-May 1

NUCLEAR MEDICINE UPDATE

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Radiology Division of Nuclear Medicine, the UMC Division of Continuing Health Professional Education and the Mississippi Society of Nuclear Medicine.

Coordinator: Dr. Edward L. Gieger, Jr., clinical instructor of radiology.

This sixth annual meeting presents the latest and most comprehensive information on clinical nuclear medicine imaging. Emphasis will be on newer techniques as well as recent advancements in established procedures. Fee: \$80. Credit: 6.5 hours AMA Category I.

Medico-Legal Brief

MD Disciplined For Practicing Under Influence of Drugs

A physician should be disciplined for making a medical judgment while under the influence of alcohol and drugs, a Georgia appellate court ruled.

The physician was called to a hospital to see another physician's patient. He examined the patient's chart, which indicated that certain diagnostic tests had been made. The physician concluded that the patient did not need further services and left to go to another hospital. En route to the other hospital, the physician was involved in a vehicular collision, which caused the deaths of two men. He later pleaded no contest to two counts of vehicular homicide in the second degree. He admitted having taken a methaqualone tablet and having had several beers prior to the accident. There was also evidence that he had also taken another drug.

The board of medical examiners brought a disciplinary action against him. It found that he had made

a medical judgment and had operated a motor vehicle while under the influence of alcohol and controlled substances. The physician's license was ordered suspended for a period of time.

The physician then appealed the board's decision, and a trial court found that there was insufficient evidence to warrant disciplinary action. Then, on appeal by the board, the appellate court reversed the trial court's decision.

The appellate court agreed that the physician's driving while under the influence of drugs and alcohol was unrelated to the practice of medicine and was insufficient to warrant disciplinary action. However, the evidence did support a finding that the physician made a medical judgment while under the influence of drugs and alcohol. The physician formed a medical opinion from his review of the patient's chart and his observation of the patient that his services were not required by the patient. The court remanded the case for determination of appropriate disciplinary action. — *Composite State Board of Medical Examiners v. Hertell*, 295 S.E.2d 223 (Ga.Ct. of App., Sept. 15, 1982)

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SOLVING THE MYSTERY OF PASCAGOULA



More than 20 years ago, a combined demonstration of medical science and community effort turned an outbreak of infectious hepatitis in Mississippi into a national landmark of disease prevention.¹

When health officials in Pascagoula, Mississippi, reported more than a dozen cases of hepatitis, the Communicable Disease Center in Atlanta assigned an epidemiologist to aid local efforts in tracing the origin of the infection.

Nurses on duty at the Jackson County Health Clinic and physicians at Singing River Hospital were interviewed, as were the patients themselves. It soon became clear that the patients had not shared a meal, had not frequented the same restaurant and had not been together in any of the most likely sites for contamination. However, a startling fact did come to light... each of the 13 infected patients had eaten raw oysters within the previous two months.

Checking and double-checking the clues...

Raw oysters were a common food in Pascagoula, but at that time shellfish were not known to cause hepatitis. As a control, 13 names were selected from the city's

telephone book. Each person questioned denied having eaten oysters, and none had symptoms of hepatitis. The investigation was narrowing down, but there was still much probing to be done.

...to find the cause

With the assistance of a sanitation engineer and a shellfish expert, the investigators began the tedious task of inspecting the local stores, oyster plants, packagers and shucking companies. Finally, they found the source of the infections: an oyster bed at the mouth of the Pascagoula River, ordered closed to oystering some 30 years earlier because it was polluted.

The diligent work of 20 specialists—epidemiologists, virologists, bacteriologists, internists, pediatricians and public health officers—had led to an awareness of shellfish as potential hepatitis carriers, and to the need for closely regulating both shellfishing and water pollution protections. The work done in Pascagoula stands as a remarkable joint effort in the history of modern medicine in the United States.

Reference: 1. An era of specialists, chap 5, in Lee RV, Eimerl S *et al.* *The Physician* New York, Life Science Library, Time Inc., 1967, pp 107-109



When the history reveals anxious depression...

For the estimated 70 percent of nonpsychotic depressed patients who are also anxious,¹ Limbitrol provides both amitriptyline, specific for symptoms of depression, and the effects of Librium® (chlordiazepoxide HCl), the tested and dependable anxiolytic. Limbitrol is, therefore, a better choice for these patients than dual agents that contain a phenothiazine, a class of antipsychotic drugs used infrequently in nonpsychotic patients.¹

62% of Overall Improvement...Within the First Week

Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.²

In another multicenter study,³ the following symptoms associated with anxious depression were significantly reduced during the first two weeks of therapy:

- ☐ Headache—79%
- ☐ Early insomnia—91%
- Middle insomnia—87%
- Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.³

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jarvik ME; New York, Appleton-Century-Crofts, 1977, p. 316. 2. Feighner JP *et al*: *Psychopharmacology* 61:217-229, Mar 1979. 3. Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

In moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Please see summary of product information on following page.

LIMBITROL® TABLETS™ Tronquizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, Prescription Paks of 50.

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HEMATOLOGIST-ONCOLOGIST seeks associate or solo practice. Contact Thomas Twele, M.D., 272 Shadow Mountain, El Paso, TX 79912.

PATHOLOGIST-ONCOLOGIST seeks practice location. Frank P. Urso, M.D., P. O. Box 1149, Akron, OH 44301.

FAMILY PRACTICE resident seeks practice location in July 1983. Contact John D. Sites, M.D., 2002 Philip Dr., Muncie, IN 47302.

ANESTHESIOLOGIST seeks to relocate in state in solo, group or institutional practice. Contact M. T. Olivo, Jr., M.D., Box 794, Oxford, MS 38655.

SURGEON seeks location with established group in small city. Currently service as chief surgical resident at Ochsner Foundation Hospital. Available July 1983. Contact Thomas C. Kelly, M.D., 1516 Jefferson Highway, New Orleans, LA 70121.

PEDIATRICIAN seeks practice location in central or Gulf Coast area upon completion of residency in July 1983. Contact Steven D. Eggen, M.D., Alton Ochsner Medical Foundation, 1516 Jefferson Highway, New Orleans, LA 70121.

PATHOLOGIST seeks position in community hospital setting upon completion of residency in June 1983. Contact Robert J. Sinnenberg, M.D., Box 662 MCV Station, Medical College of Virginia, Richmond, VA 23298.

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American Medical Association, Annual Meeting, June 19-23, 1983, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

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DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clark, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Richard C. Carter, Pres. and Secy., 314 W. Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panoia, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Pendergrass, Secy., 201 Hospital Dr., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

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The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

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735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
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Forrest General Hospital
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Hattiesburg, MS 39401

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1225 N. State Street
Jackson, MS 39201

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Memorial Hospital Consortium
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Biloxi, MS 39531

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Greenville, MS 38701

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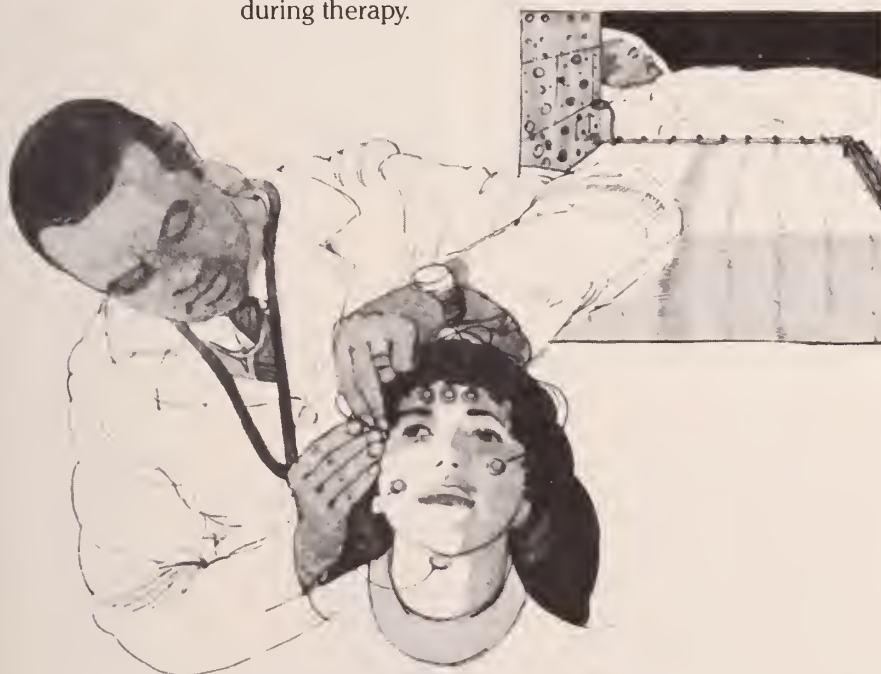
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- Caution patients about drinking alcohol, driving or operating hazardous machinery during therapy.



References: 1. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 4. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 5. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Kales JD: *Pharmacol Physicians* 4:1-6, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5:25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The

sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GI complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. **Adults:** 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

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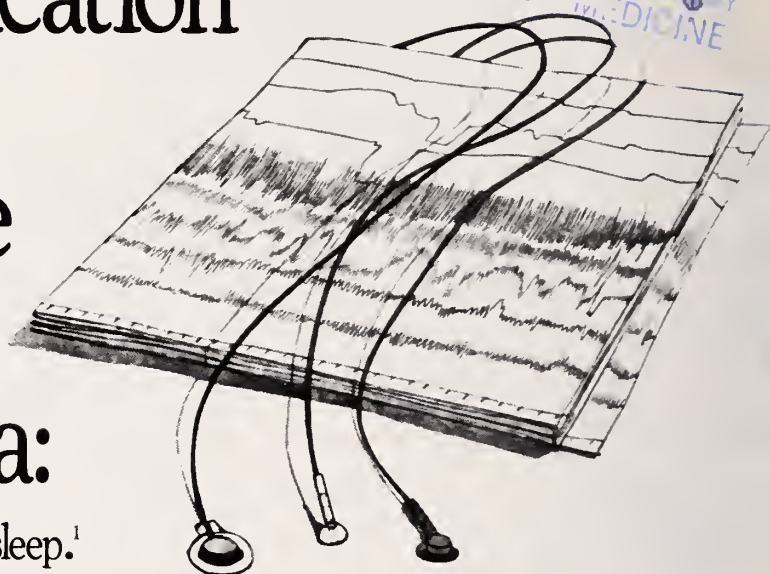
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East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clark, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Richard C. Carter, Pres. and Secy., 314 W. Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Pano-la, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. S. B. Fineberg, Sec'y., 2204 Old Mobile Hwy., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Pendergrass, Secy., 201 Hospital Dr., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

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316 Medical Arts Building
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Northwest Mississippi Regional Medical Center
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DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 µg/ml and 0.09 µg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS **PREGNANCY:** VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets. VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
December 1979

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**"Because You Love Your Baby,
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According to Dr. Roland B. Robertson, Jr. of Jackson, president of the Mississippi Lung Association, the two-part program, "Because You Love Your Baby, There Has Never Been a Better Time to Quit Smoking," offers information, handbook, charts, and full color posters to health care providers for use in counseling sessions. There is also a companion package available for pregnant women which provides useful information for smoking cessation and reinforces the counselor's message.

"National statistics show that nearly half the American pregnant women do not know how smoking affects the outcome of pregnancy. It is vital that pregnant women understand the health hazards of smoking," Dr. Robertson added.

The American Lung Association created the "Smoking and Pregnancy" kits for practitioner and patient to make it possible for the busy practitioner to educate patients for "life and breath." The new program helps pregnant women understand why they should quit smoking for themselves and their babies and encourages the use of the "Freedom From Smoking" program, a self-help program for persons wanting to quit smoking.

For more information on the new "Smoking and Pregnancy" program or to order materials, contact us.

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(BRIEF SUMMARY)

DESCRIPTION: Each tablet contains 200 mg meprobamate and 325 mg aspirin.

INDICATIONS: Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease. Clinical trials demonstrated in these situations relief of pain is somewhat greater than with aspirin alone. Effectiveness in long-term use, i.e., over 4 months, has not been assessed by systematic clinical studies. Physicians should periodically reassess usefulness of drug for individual patients.

CONTRAINDICATIONS: ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds. MEPROBAMATE: Acute intermittent porphyria; allergic or idiosyncratic reactions to meprobamate or related compounds, e.g., carisoprodol, meprobamate, or carbomalonate.

WARNINGS: ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes.

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo. Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g., anxiety, anorexia, or insomnia, or withdrawal reactions, e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinations, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually cease

within next 12- to 48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g., driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chloridazepam, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical cord blood of or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic[®] M is not recommended for patients 12 years of age and under.

PRECAUTIONS: ASPIRIN: Salicylates an-

tagonize uricosuric activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney; to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS: ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, hypotensive crisis.

GI: Nausea, vomiting, diarrhea.

CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate, meprobamate and carbomalonate, carbomalonate and meprobamate, carbomalonate and carbomalonate.

Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and

bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSEAGE AND ADMINISTRATION: Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE: Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed. Induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdosage (meprobamate alone): Death has been reported with ingestion of as little as 12 gram meprobamate and survival with as much as 40 gram.

BLOOD LEVELS: 0.5-2.0 mg percent represents usual blood-level range after therapeutic doses. The level may occasionally be as high as 3.0 mg percent. 3-10 mg percent usually corresponds to

findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma.

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur. At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdosage (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration.

Relapse and death, after initial recovery have been attributed to incomplete gastric emptying and delayed absorption.

HOW SUPPLIED: Bottles of 50 scored tablets.

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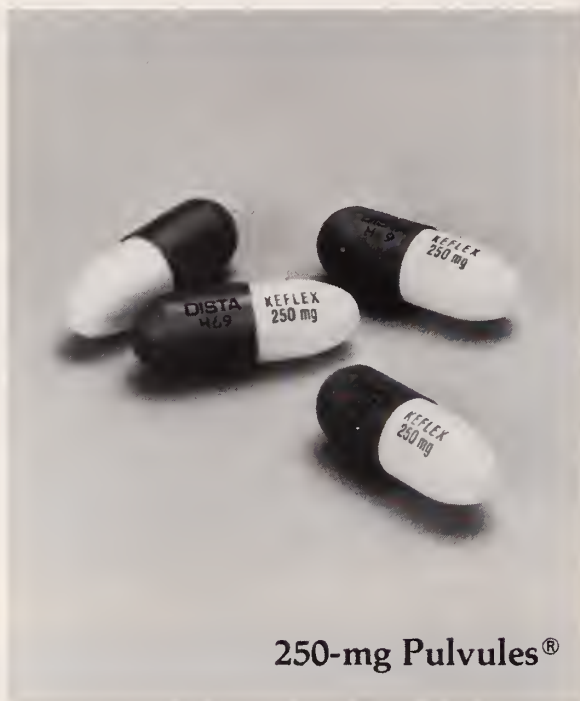
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NEWSLETTER

May 1983

Dear Doctor:

An outbreak of measles in the Meridian area has prompted warnings from some state health officials about possible susceptibility to the disease in many young people vaccinated prior to 1968, when more effective vaccines became available. Although the Meridian cases involved five children too young to be immunized, officials caution that many people still do not realize the need for their children to be immunized before they reach school age.

The possible susceptibility in persons 16 to 25 years old raises concerns about an occurrence similar to one in Indiana in March, when about 200 college students contracted the disease. Nearly 31,000 college students were subsequently re-vaccinated.

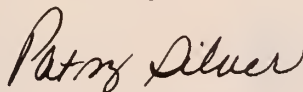
The AMA and FTC agreed to language that would clarify the agency's jurisdiction over state-licensed professions. The joint proposal would protect traditional state licensure of professionals from FTC interference. State laws defining the scope of professional practice would also be protected. Commercial activities of professionals, such as the setting of fees, would be subject to FTC scrutiny.

The AMA and the American Nurses Association jointly called for analysis of new health care systems for the aged. In recommendations that were accepted by the AMA board for transmittal to the house, an AMA/ANA Task Force said that this analysis could be funded by the National Institute on Aging.

The American Academy of Pediatrics has received support from other organizations in its legal challenge of the controversial "Baby Doe" rule forcing medical institutions to post a hotline number for reporting suspected cases of denial of food or medical treatment to handicapped infants. Objections charge the HHS rule attempts to prescribe medical practice, and may lead to overtreatment of some infants, simply prolonging the process of death.

This issue of your journal includes a new feature called "Comment." Members are invited to submit their viewpoints on medical issues for discussion in this forum. If you have an idea, a suggestion, or just want to give your opinion about an issue, write to "Comment," P.O. Box 5229, Jackson, MS 39216.

Sincerely,



Patsy Silver
Managing Editor

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References

1. Stone PH, Turz G, Muller JE. Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104: 672-681, September 1982
2. Antman E, Muller J, Goldberg S, et al. Nifedipine therapy for coronary-artery spasm. Experience in 127 patients. *N Engl J Med* 302: 1269-1273, June 5, 1980

BRIEF SUMMARY

PROCARDIA* (nifedipine) CAPSULES

For Oral Use

INDICATIONS AND USAGE: I. **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation; 2) angina or coronary artery spasm provoked by ergonovine; or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers, if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates. PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis. Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy. Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients; transient hypotension in about 5%; palpitation in about 2%; and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGPT and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholelithiasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77° F (15° to 25° C) in the manufacturer's original container.

More detailed professional information available on request.

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joining the human race again."*



*Quotes from an unsolicited
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angina patient. While this patient's experience
is representative of many
unsolicited comments received,
not all patients will respond to
Procordia nor will they all
respond to the same degree.*

*"My daily routine consisted of
sitting in my chair trying to stay alive."*

*"My doctor switched me to
PROCARDIA[*] as soon as it became
available. The change in my condition
is remarkable."*

*"I shop, cook and can plant
flowers again."*

*"I have been able to do volunteer
work...and feel needed and useful
once again."*

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,¹ taking fewer nitroglycerin tablets,² doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

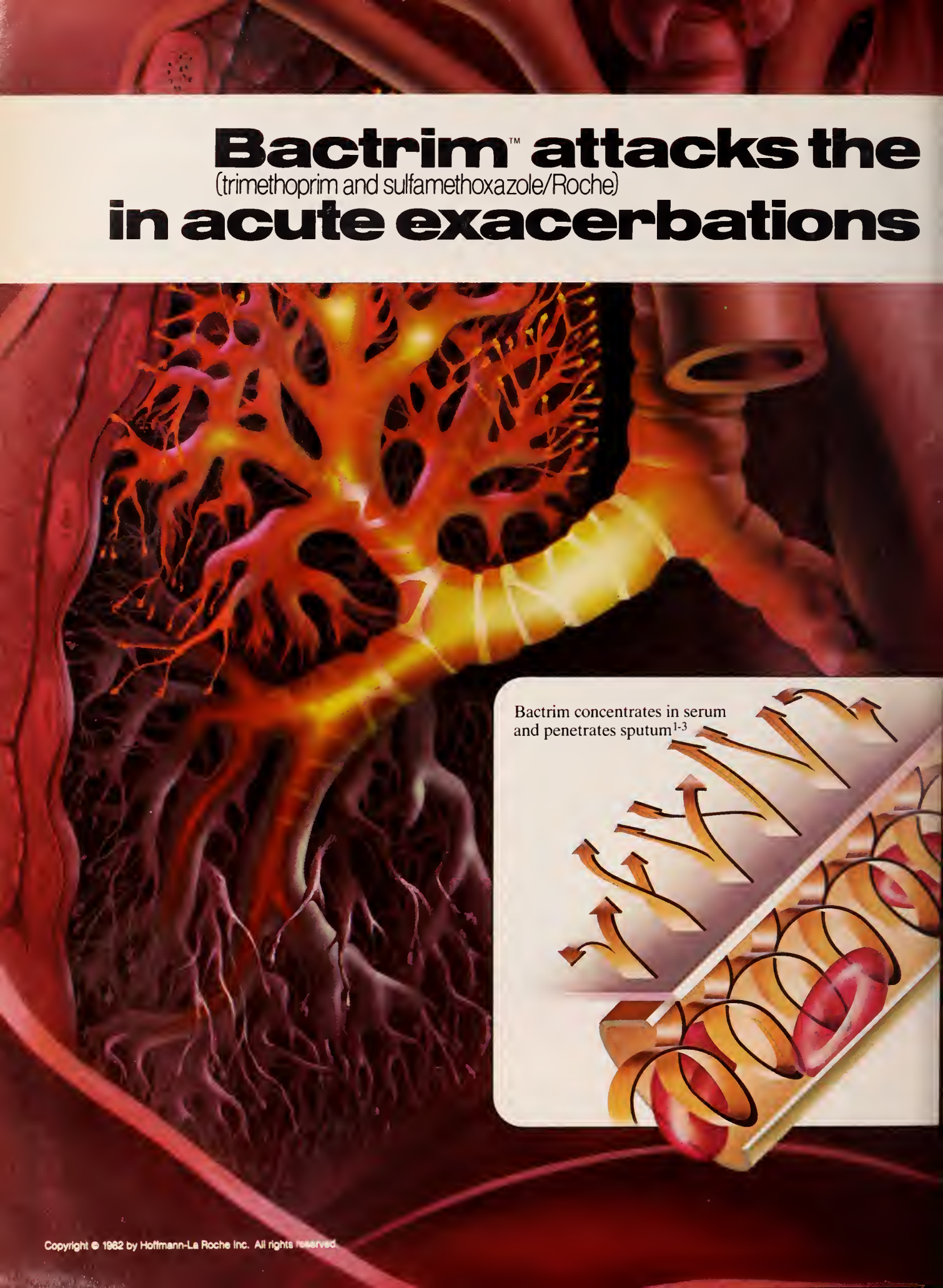
* Procordia is indicated for the management of:

- 1) Confirmed vasospastic angina
- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

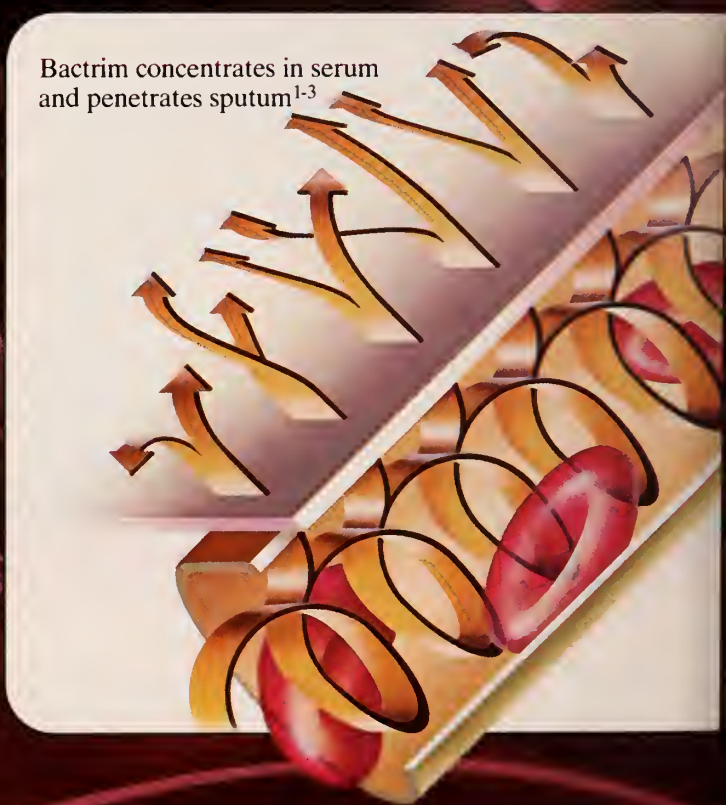
PROCARDIA[®]
(NIFEDIPINE) Capsules 10 mg

Please see PROCARDIA brief summary on adjoining page

Bactrim™ attacks the (trimethoprim and sulfamethoxazole/Roche) **in acute exacerbations**



Bactrim concentrates in serum
and penetrates sputum¹⁻³



major pathogens of chronic bronchitis*

Bactrim clears sputum of susceptible bacteria

In sputum cultures from patients with acute exacerbations of chronic bronchitis, *H. influenzae* and *S. pneumoniae* are isolated more often than any other pathogens.^{4,5} One study of transtracheal aspirates from 76 patients with acute exacerbations found that 80% of the isolates were of these two pathogens.⁵

Bactrim is effective *in vitro* against most strains of both *S. pneumoniae* and *H. influenzae*—even ampicillin-resistant strains. And in acute exacerbations of chronic bronchitis involving these two pathogens, sputum cultures taken seven days after a two-week course of therapy showed that Bactrim eradicated these bacteria in 91% (50 of 55) of the patients treated.⁶

Bactrim reduces coughing and sputum production

In three double-blind comparisons with ampicillin *q.i.d.*, Bactrim DS proved equally effective on all clinical parameters.^{7,9} Bactrim reduced the frequency and severity of coughing, reduced the amount of sputum produced and cleared the sputum of purulence.

Bactrim has the added advantages of *b.i.d.* dosage convenience and a lower incidence of diarrhea than with ampicillin, and it is useful in patients allergic to penicillins.

Bactrim also proved more effective than tetracyclines in 10 clinical trials

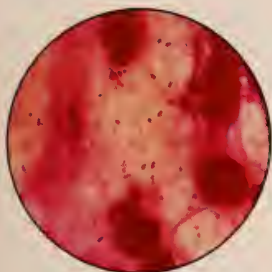
involving nearly 700 patients.¹⁰ Overall clinical condition of the patients, changes in sputum purulence, reduction in sputum volume and microbiological clearance of pathogens—all improved more with Bactrim therapy than with tetracyclines. G.I. side effects occurred in only 7% of patients treated with Bactrim compared with 12% of tetracycline-treated patients. (See Adverse Reactions in summary of product information on next page.)

Bactrim is contraindicated in pregnancy at term and nursing mothers, infants under two months of age, documented megaloblastic anemia due to folate deficiency and hypersensitivity.

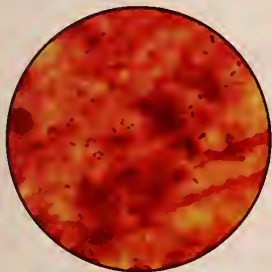
Bactrim DS. For acute exacerbations of chronic bronchitis in adults* when it offers an advantage over single-agent antibacterials.

References: 1. Hughes DTD, Bye A, Hodder P: *Adv Antimicrob Antineoplastic Chemother* 1/2:1105-1106, 1971. 2. Jordan GW et al: *Can Med Assoc J* 112:91S-95S, Jun 14, 1975. 3. Beck H, Pechere JC: *Prog Antimicrob Anticancer Chemother* 1:663-667, 1969. 4. Quintiliani R: Microbiological and therapeutic considerations in exacerbations of chronic bronchitis, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts*; Princeton Junction, NJ, Communications Media for Education, Inc., 1980, pp. 9-12. 5. Schreiner A et al: *Infection* 6(2):54-56, 1978. 6. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 7. Chodosh S: Treatment of acute exacerbations of chronic bronchitis: results of a double-blind crossover clinical trial, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts*. *Op. cit.*, pp. 15-16. 8. Chervinsky P: Double-blind clinical comparisons between trimethoprim-sulfamethoxazole (Bactrim™) and ampicillin in the treatment of bronchitic exacerbations. *Ibid.*, pp. 17-18. 9. Dulfano MJ: Trimethoprim-sulfamethoxazole vs. ampicillin in the treatment of exacerbations of chronic bronchitis. *Ibid.*, pp. 19-20. 10. Medici TC: Trimethoprim-sulfamethoxazole (Bactrim™) in treating acute exacerbations of chronic bronchitis: summary of European clinical experience. *Ibid.*, pp. 13-14.

attacks *H. influenzae*—even
ampicillin-resistant strains



attacks *S. pneumoniae*



Economical b.i.d.

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole/Roche)

*Due to susceptible organisms. Please see next page for summary of product information.

Bactrim™

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Use: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections. For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonia.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS.

Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folate metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage. 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).



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New Variable Interest Rate.

Looking for an ideal investment? One with a variable interest rate? But one where rates can't drop below a certain level?

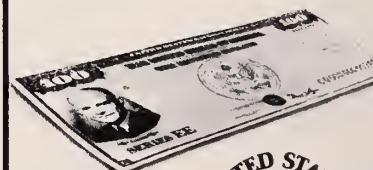
Well, there is one available to everyone, even if you have only \$25 to invest.

It's U.S. Savings Bonds. Now changed from a fixed to a variable interest rate, with no limit on how much you can earn.

A Guaranteed Minimum.

Although interest rates will fluctuate, you're protected by a guaranteed minimum. And if you hold your Bond to maturity, you'll double your money. You may do even better.

Take another look at Savings Bonds. We did, and made them better.

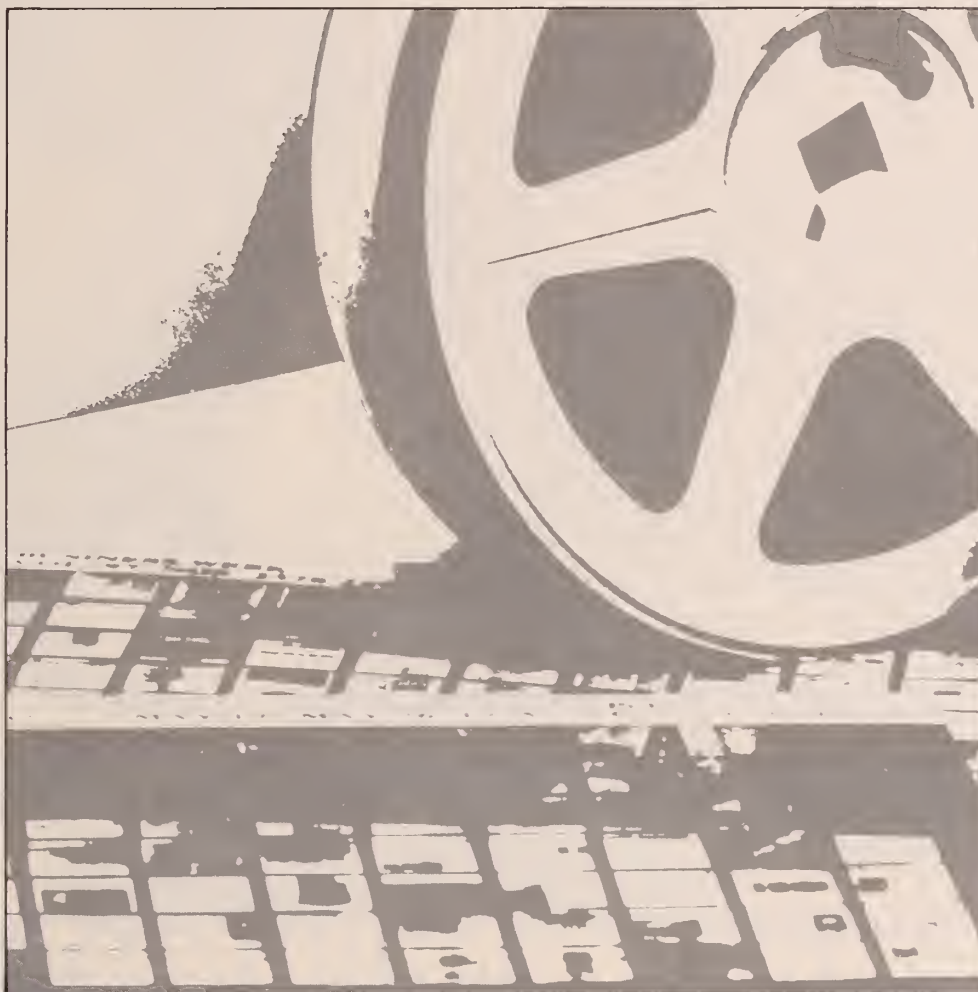


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She's back. How can you help her this time?

Many patients presented with physical symptoms are suffering from psychiatric illness, but are unaware of it. And while not all who suffer from mental illness or emotional problems need hospital treatment, hospitalization may be essential to provide a therapeutic environment in which the patient can effectively deal with his or her problems.

Riverside Hospital is a 56-bed, short-term care facility which provides intensive treatment of patients suffering from psychiatric illnesses, alcoholism, and drug dependencies. In Riverside's open, non-institutional environment, traditional and new, progressive psychotherapies are utilized.

Above all, care at Riverside is aimed at treating the patient with respect and dignity, fostering self-esteem, and returning the patient to independence and a satisfying, productive and happy life.

Riverside is licensed by the Mississippi Commission on Hospital Care, and is fully accredited by the Joint Commission on Accreditation of Hospitals.

The medical staff includes a large number of psychiatrists in private practice in the Jackson area. A toll-free number, 1-800-962-2180, has been established at the hospital for referral service to physicians on the active medical staff.

Physicians who have patients who would benefit from the type of treatment approach offered by Riverside may obtain referral information by contacting the Director of Admissions.

Riverside Hospital

P.O. Box 4297, Jackson, Mississippi 39216

Telephone: (601) 939-9030

Incoming Mississippi WATS: 800-962-2180

DATELINE

MSMA Expands CommuniCare Program

Jackson, MS - CommuniCare, MSMA's patient inquiry program, has been expanded to include the entire state. The program emphasizes the importance of good communications in the physician-patient relationship. A full-time staff handles inquiries through procedures designed to preserve that relationship. CommuniCare, established under direction of the Board of Trustees with the approval of the House, has operated on a pilot basis since last fall.

Smoking and Pregnancy Info Kits Available

Jackson, MS - "Statistics show that nearly half the American pregnant women do not know how smoking affects the outcome of pregnancy," said Dr. Roland B. Robertson, Jr., president of the Miss. Lung Association, in a statement announcing a new "Smoking and Pregnancy" educational program. The program offers information packets -one for pregnant women and one designed for use by physicians in counseling. They may be ordered from the MLA.

CDC Cancels Some Lab Services

Jackson, MS - The Centers for Disease Control will no longer provide routine diagnostic services for which satisfactory reagents or tests are commercially available. This ruling affects most of the specimens currently forwarded through the Mississippi Public Health Laboratory to the CDC. Physicians may call the Lab (354-6672) if they have questions concerning the acceptance of specimens or if they seek information on commercially available tests.

UMC Receives Culpeper Award

Jackson, MS - The University of Mississippi Medical Center has been selected to receive a Charles E. Culpeper Foundation Visiting Professorship Award. The award, which is made for a five-year period, will bring to the health sciences campus outstanding lecturers in surgery, pediatrics, radiology and immunology or genetics, and will cover honorarium and expenses for a stay of at least two and one-half days.

Warning Label Is Termed Premature

Chicago, IL - A relationship between the use of salicylates and the development of Reye's syndrome among children has not been clearly established by existing studies, the AMA said in comments to the FDA on a proposal to require a warning label on salicylate-containing products. The AMA said that it concurred with the American Academy of Pediatrics that a warning label on all over-the-counter and prescription products would be premature.

AMA Hospital Medical Staff Members:

**Strengthen Your Role
In Decision-Making...
Influence AMA Policy!**



As a Hospital Medical Staff Representative, you should plan now to attend this four-day AMA Hospital Medical Staff Section Assembly Meeting. You will have an opportunity to contribute to the decision-making process and participate in developing policy that will address the issues and concerns of physicians on hospital staffs.

The AMA Hospital Medical Staff Section will provide representatives from hospital medical staffs with a forum to discuss common problems and changes in Physician-Hospital Relations, and a direct voice in policies being considered by the American Medical Association.

Group sessions will be conducted on various topics of interest to hospital medical staff members. Potential issues for discussion include: medical staff representation, staff privileges, and overall relationships between physicians and hospitals.

Here's your opportunity to effect change. For information contact the AMA Department of Hospital Medical Staff Services at (312) 751-6476.

Anxious patients improve in just a few days

And what is more reassuring to an excessively anxious patient than medication that promptly starts to relieve his discomforting symptoms? Valium® (diazepam/Roche) begins working within 30 to 90 minutes. Patients continue to improve in just a few days, and relief continues throughout the course of treatment.

There are other important benefits with Valium as well—along with its broad clinical range, Valium has an efficacy/safety profile that few, if any, drugs can match. This record has been achieved with extensive clinical experience, undoubtedly including yours. And, as you must have observed, side effects more serious than drowsiness, fatigue or ataxia rarely occur. Nevertheless, as with any CNS-acting agent, patients should be cautioned about driving, operating hazardous machinery or ingesting alcohol or other CNS-depressant drugs while taking Valium.

Yet another benefit Valium affords is flexibility.






Available in 2-mg, 5-mg and 10-mg scored tablets, Valium enables you to titrate dosage to individual patient needs. For the geriatric patient, a starting dosage of 2 to 2½ mg once or twice a day is recommended. And, for patients who forget or skip medication, you can prescribe Valrelease™ (diazepam/Roche) 15-mg slow-release capsules,

knowing that Valrelease will assure all the benefits of Valium 5 mg *t.i.d.* with the convenience of once-a-day dosage.

Discontinuation of Valium (or Valrelease) is typically as smooth as its start in short-term therapy. However, Valium and Valrelease should be discontinued gradually after more extended treatment. As you diminish dosage, the built-in tapering action of Valium and Valrelease will help avoid rapidly recurring anxiety symptoms and symptoms of withdrawal, and will help ease the patient's transition to independent coping when therapeutic goals have been achieved.

...that's one of
the unique benefits of
Valium®
diazepam/Roche

Valium® (diazepam/Roche)  Tablets
Valrelease™ (diazepam/Roche)  slow-release Capsules
Injectable Valium® (diazepam/Roche) 

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly; taking at least one minute for each 5 mg (1 ml) given, do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over sedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity,

insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL Adults: Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) **tablets**, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 **Valrelease capsules** (15 to 30 mg) daily. Acute alcohol withdrawal—**tablets**, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 **capsules** (30 mg) the first 24 hours, then 1 **capsule** (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—**tablets**, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 **capsules** (15 to 30 mg) once daily. Adjunctively in convulsive disorders—**tablets**, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 **capsules** (15 to 30 mg) once daily.

Geriatric or debilitated patients: **Tablets**—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). **Capsules**—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: **Tablets**—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). **Capsules**—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary; Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children administer I.V. slowly; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levaterenol or metaraminol for hypotension. Dialysis is of limited value.

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ORIGINAL PAPERS

Trauma Associated With Three-Wheeled Recreational Vehicles

W. G. MCDONALD, M.D. and

J. G. STRIBLING, M.D.

Jackson, Mississippi

ALTHOUGH THREE-WHEELED recreational vehicles have been used as transportation for farmers and sportsmen who need access to wet, swampy terrain, more recently, their role has expanded to a joy riding, recreational vehicle which can go anywhere and do almost anything. This recreational use has spawned a large market for these machines as well as a new source of injury arising from their misuse. Because of increasing numbers of injuries related to the three wheelers, we decided to characterize the type of injuries to see what solution to this mounting problem there might be.

Method

The study population was comprised of all patients who sought care in Jackson, Mississippi from emergency departments of St. Dominic Hospital, Mississippi Baptist Medical Center, and Rankin General Hospital.

Forty-five consecutive cases with the chief complaint of three-wheeler accidents were collected over a four-month period from March 1982 to June 1982 from the above emergency departments. In all cases charts were reviewed with attention to mechanism of injury, protective gear used, type of injury sustained, and age of the operator.

Results

During the period of the study, the 45 patients seen had a total of 61 injuries ranging from simple

Significant severe injuries requiring hospitalization and including fracture occur as a result of mishap on three wheeled recreational vehicles. These injuries occur predominately in males less than 16 years of age. Parental education along with governmental control, protective gear including helmet and patient education may be helpful in decreasing morbidity.

abrasion to depressed skull fracture. Males were involved in 78 percent of the episodes. The age range was seven years to 75 years with most injuries occurring in teenagers and young adults.

Fractures were the most commonly occurring injury with 45 percent of patients seen having sustained some type of fracture. Other injuries are shown in Table I with lacerations, contusions, abrasions, and displaced joints accounting for most of the other injuries. No fatalities were seen.

The distribution of injury for bone injury, soft tissue injury, laceration, and dislocation are summarized in Figure 1 with bone injury and dislocation occurring predominantly above the waist. Lacerations are primarily facial or scalp in distribution and soft tissue injury occurring in a uniform distribution over the body.

Of the 45 patients seen in the emergency departments, seven required hospitalization for their injuries. The age of these patients is summarized in Figure 2.

Drs. Stribling and Bell are specialists in emergency medicine in Jackson, Mississippi.

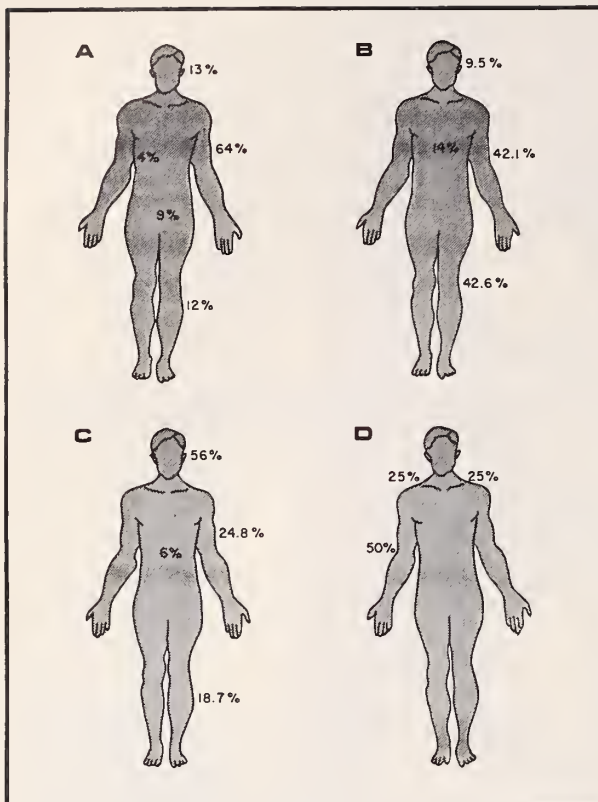


Figure 1

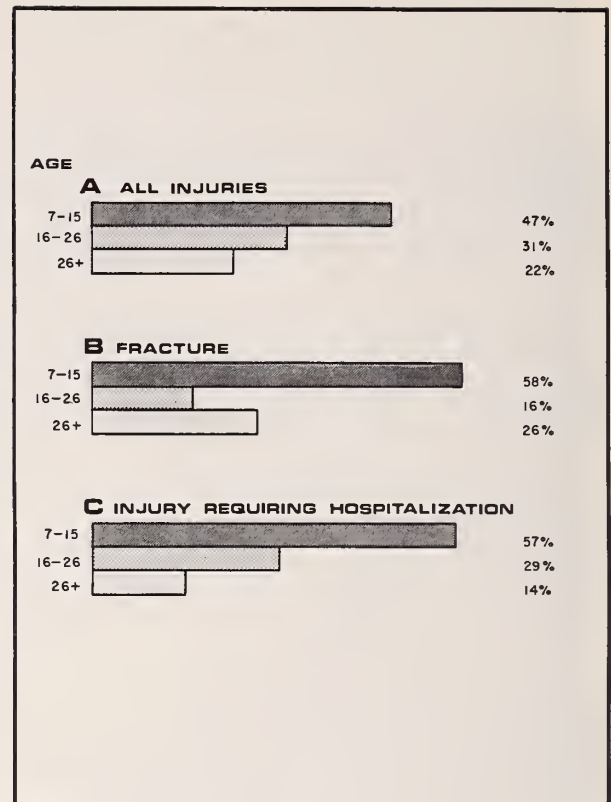


Figure 2

An age distribution for all injuries and for fractures indicate in Figure 2 that children less than 16 years of age are the most often injured.

Discussion

Clearly, significant injuries are being sustained in accidents involving a vehicle which is considered recreational. Most accidents on three-wheelers appear to be at low speed when compared to motorcycle or automobile accidents and usually involve complete loss of control of the machine. "Lost control and flipped over or was thrown off" caused injuries three times more often than "hit another object" (tree, car, person, another three-wheeler). One notable case involved an adolescent hit by an automobile while chasing a runaway three-wheeler. About 30 percent of accidents occur on hard surface road where the vehicles are considered most unstable by experienced riders and illegal by law enforcement authorities.

Fractures are the most common injury. Eighty-two percent of people seen had injury worthy of radiologic study and of these, half of the patients had studies positive for fracture or fracture-dislocation.

The fractures occur most commonly in the upper extremity. The mechanism of injury appears to be similar to over the handlebars motorcycle injury and mechanical bull injuries. These fractures occur most commonly in patients of the age range of seven to 15 years.

Lacerations requiring suture are often seen in association with three-wheeler accidents. Fifty-six percent of lacerations were found on the face or scalp. One subtotal amputation of the nose could not be sutured. The majority of the rest of the lacerations occur on the upper extremity.

In none of the cases was any protective gear found on patients or admitted to by patients who were questioned. Most patients were seen clad in tennis shoes, t-shirts or thin blouses, and about half were wearing shorts.

Of those patients requiring hospitalization for management of their injuries (persistent hematuria, depressed skull fracture, blow-out fracture of the orbit, compression fracture of the lumbo-sacral spine, extensively contaminated wound), the majority were less than 16 years of age.

Recommendations

The areas of concern which appear reversible warrant discussion. These are facial injuries and debilitating injuries.

The major debilitating injuries are fracture and those severe injuries requiring hospitalization. The majority of these injuries occur in young adolescents and children with 58 percent of fracture victims and 57 percent of severe injuries less than 16 years of age. Enforcable *government control*, while easy to recommend, may be difficult to obtain in areas where these vehicles are ridden, especially when the emphasis of government at all levels is to control spending. Education in driver technique would be easy to require at time of purchase, but the person who purchases the vehicle (parent) is not usually the one who is injured misusing it (adolescent son). Driver education programs have not had an excellent track record. In the only controlled study done on educated vs. uneducated groups of motorcycle riders, the non-educated group actually suffered fewer injuries than did the educated group. *Protective gear* would probably be very helpful if used, but it is doubtful that compliance with protective gear would be very high since it would encumber the rider and dampen the freedom and enthusiasm of the ride. *Parental education* may possibly deter some accidents since there are probably a large number of parents who do not realize the potential for injury that these vehicles have. Parent education by their primary care physician as well as mass media exposure may be helpful when combined with the above concepts.

An easily recognized solution to the laceration problem would be the simple use of helmet with chin guard and face shield. This protective device should be easy to accept from motorcycle experience, and the average cost of such a helmet of \$100.00 to \$130.00 retail is comparable to the average cost of repair for the simplest laceration of \$126.75.

Conclusion

Significant severe injuries requiring hospitalization and including fracture occur as a result of mishap on three wheeled recreational vehicles. These

TABLE I

Type of Injury	Number
Fracture	19
Laceration	15
Abrasion	5
Contusion	12
Hematoma	1
Dental Injury	2
Amputation of Nose	1
Displaced Joint	3
Spinal Cord Strain	1
Genitourinary	1
Concussion	1

Number of Patients with specific injury sustained in three wheeler accidents (Total Number of Patients = 45).

injuries occur predominantly in males less than 16 years of age. Parental education along with government control, protective gear including helmet and patient education may be helpful in decreasing morbidity. ★★★

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Acknowledgement

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The Status of High Blood Pressure Control in Central Mississippi

DENNIS A. FRATE, PH.D.,* SIDNEY A. JOHNSON, M.D.,* EDWARD F. MEYDRECH, PH.D., † and THOMAS R. SHARPE, PH.D.‡

THE CONTROL of high blood pressure has been a major public health priority in this country over the past 15 years.¹ The reasons behind this health services and research commitment relate to three major factors: the high prevalence of the disorder in the adult population, the relationship that uncontrolled high blood pressure has to cardiovascular morbidity and mortality, and the poor record of detection and effective treatment during the 1960's in spite of the fact that effective treatment was available. In fact, during the 1960's it was determined that about one-half of the hypertensive population nationally were unaware they had the disorder and only about one-eighth were on a treatment regimen that resulted in a controlled blood pressure.

By the mid-1970's, due to the increased attention placed on detecting hypertensives and controlling blood pressures, a greater proportion of hypertensives were diagnosed, under medication, and achieving a controlled pressure. By 1975 only about 28 percent of all hypertensives were unaware they had the disorder, while almost 45 percent were controlled.²

This method of characterizing a hypertensive population by examining the diagnostic and therapeutic status involves the evaluation of two factors: level of disease awareness and treatment status of the disorder within a defined population. Consideration of these two factors then results in the creation of four diagnostic and therapeutic statuses: unaware, untreated, inadequately treated, and controlled hypertensives. The diagnostic status "unaware" refers to individuals who have the disease but have not had the disorder clinically diagnosed. The therapeutic status "untreated" refers to individuals with diagnosed hypertension but who are not on treatment. "Inadequately treated" refers to individuals

This study examines the diagnostic and therapeutic status of hypertension in five central Mississippi counties from both a point-in-time, or cross-sectional (1981), and longitudinal (1972-1981) perspective. In 1981 over one-half of all hypertensives were diagnosed, on treatment, and had achieved a controlled blood pressure. Detection, treatment, and successful treatment outcome for high blood pressure was not associated with race per se but was statistically related to age and to race and sex. The authors report that during the past nine years great strides have been made in this locale in controlling this major chronic disease.

on treatment for the diagnosed disorder but yet who have an elevated blood pressure. Finally, the status "controlled" is a classification indicating successful treatment of the diagnosed disorder. The specific levels used to designate successful treatment, or a controlled blood pressure status, vary. Generally, an individual on medication with a systolic less than 160 mm and a diastolic of less than 95 mm is classified as having a controlled blood pressure. By examining a hypertensive population in this fashion, insight can be gained into a variety of health-related areas, including utilization of health services, compliance rates with antihypertensive treatment regimens, general knowledge by the consumer about the consequences of uncontrolled high blood pressure, and the quality of primary medical services. Further examination of these diagnostic and therapeutic statuses by such demographic characteristics as age, sex, and race can also provide information to more effectively direct the activities of focused intervention programs in an effort to identify high risk groups.

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The present study examines the diagnostic and therapeutic status of hypertension in central Mississippi from both a point-in-time, or cross-sectional, and a longitudinal perspective. The point-in-time perspective is taken from a study conducted in early 1981 as part of a five-year research and demonstration project designed to measure the health and cost effectiveness of new approaches to controlling high blood pressure. These data were obtained from a survey conducted on a representative five-percent sample of the population in the five-county study area in central Mississippi. This survey was conducted in order to determine a baseline measure of the prevalence rate of high blood pressure, the diagnostic and therapeutic status of hypertension, and the level of knowledge and attitudes about the disorder among the general population. Trained health counselors took two blood pressure measurements using mercury sphygmomanometers and employing the first and fifth phase Korotkoff sounds to designate the systolic and diastolic pressures, respectively.

The longitudinal comparison is drawn from blood pressure screening data obtained from a 1972 effort conducted only on blacks residing in one county that

was resurveyed in the 1981 study; similar blood pressure measurement techniques as used in 1981 were employed on this randomly selected population.

Results

Analysis of the diagnostic and therapeutic status of hypertension in the five-county study area in central Mississippi by age, race, and sex was conducted using the Grizzle-Starmer-Koch linear models' approach for categorical data.³ Tables 1 and 2 summarize the findings of this analysis. As shown in Table 1 the distribution of the diagnostic and therapeutic status of hypertension varies significantly ($P = 0.0007$) by age with individuals in the 20-44-year cohort being less controlled and more unaware of their condition than either those persons in the 45-69-year cohort or the 70-year-and-older cohort; no other differences were found.

Table 2 shows the distribution of the diagnostic and therapeutic status of hypertension in this population by race and sex. By examining the total percentage column for blacks and whites it can be seen that race *per se* does not appear to have any relationship to whether a hypertensive is diagnosed, on treatment, or controlled, as about 60 percent of the adult black hypertensives and 64 percent of the adult white hypertensives were on treatment and achieving a controlled blood pressure. However, closer scrutiny does indicate an interaction between the effects of the race and sex factors on the diagnostic and therapeutic status. In particular, black males vary significantly ($P = 0.0005$) from the other three groups; over 60 percent of the adult black females, adult white males, and adult white females are achieving a controlled blood pressure while only about 50 percent of the adult black male hypertensives are similarly controlled. None of the other cohorts differed significantly from each other.

TABLE 1

DIAGNOSTIC AND THERAPEUTIC STATUS OF
HYPERTENSION IN CENTRAL MISSISSIPPI BY AGE, 1981

Diagnostic and Therapeutic Status	20-44		45-69		70 +	
	No.	%	No.	%	No.	%
Unaware	34	23.0	52	11.3	31	11.2
Untreated	16	10.8	28	6.1	17	6.1
Inadequately						
Treated	16	10.8	91	19.8	55	19.9
Controlled	<u>82</u>	<u>55.4</u>	<u>289</u>	<u>62.8</u>	<u>174</u>	<u>62.8</u>
Total	148	100.0	460	100.0	277	100.0

TABLE 2

DIAGNOSTIC AND THERAPEUTIC STATUS OF HYPERTENSION IN CENTRAL MISSISSIPPI BY RACE AND SEX, 1981

Diagnostic and Therapeutic Status	Male		Black Female		Total		Male		White Female		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Unaware	40	19.6	24	7.7	64	12.4	32	19.4	21	10.3	53	14.4
Untreated	15	7.4	20	6.4	35	6.8	8	4.9	18	8.8	26	7.0
Inadequately												
Treated	47	23.0	62	19.9	109	21.1	21	12.7	32	15.7	53	14.4
Controlled	<u>102</u>	<u>50.0</u>	<u>206</u>	<u>66.0</u>	<u>308</u>	<u>59.7</u>	<u>104</u>	<u>63.0</u>	<u>133</u>	<u>65.2</u>	<u>237</u>	<u>64.2</u>
Total	204	100.0	312	100.0	516	100.0	165	100.0	204	100.0	369	100.0

Finally, Table 3 compares the diagnostic and therapeutic status of black hypertensives screened in 1972 to blacks screened from the same area in 1981. The distributions are significantly different ($P < 0.0001$). In 1972 about 32 percent of all hypertensives were previously unaware of their disorder.⁴ This proportion fell in 1981 to less than 15 percent. In 1972 only about 24 percent were under treatment and achieving a controlled blood pressure. This proportion was over twice as great in 1981, when 53 percent of all hypertensives were controlled.

TABLE 3
DIAGNOSTIC AND THERAPEUTIC STATUS OF ADULT
BLACK HYPERTENSION, 1972 and 1981

Diagnostic and Therapeutic Status	1972		1981	
	No.	%	No.	%
Unaware	461	32.0	28	14.5
Untreated	154	10.7	15	7.8
Inadequately Treated	486	33.7	47	24.4
Controlled	340	23.6	103	53.3
Total	1441	100.0	193	100.0

Discussion

Examination of the diagnostic and therapeutic status of hypertension in a population by selected demographic characteristics provides insight into the relationship between a chronic disorder and the local medical care system. Considering the results, the 1981 survey demonstrates that race *per se* was not significantly related to the four diagnostic and therapeutic statuses. Younger individuals and black males, when compared to older-aged cohorts and to whites and black females, had a greater chance of not being aware of the disorder and of having uncontrolled hypertension.

As illustrated, high risk groups then become easily identifiable through this type of analysis. For example, individuals 20-44 years of age and black males in general are the most unsuccessful groups to interact with the medical care system especially concerning the detection and control of high blood pressure. Specifically, black males have a high probability of having undiagnosed or uncontrolled high blood pressure.

Overall, these data reflect favorably on the impact the local medical care system is making toward controlling this chronic disease. For example, in 1981 over 80 percent (417/516) of all black hypertensives and almost 75 percent (290/369) of white hypertensives were under treatment. The local medical care system has responded by diagnosing and treating this chronic disease. The fact that only 7 percent of both white and black hypertensives were diagnosed but untreated also reflects consumer awareness of the consequences of this disorder.

The relative success of the local medical care system in diagnosing and managing high blood pressure is also reflected in the relative improvement that occurred over a nine-year period (see Table 3). For example, in 1972 about 57 percent (826/1441) of all black hypertensives were in the medical care system with diagnosed hypertension which was under treatment. By 1981 this figure rose to over 77 percent (150/193) of all hypertensives. In other words, in 1972 two out of every five hypertensives were either undiagnosed or diagnosed and not on treatment. In 1981 only about one of every five hypertensives were similarly undiagnosed or diagnosed and not on treatment. Consequently, great strides have been made by the local medical care system in the detection and treatment of high blood pressure. Such a finding could possibly be related to either the quality of the local medical care services offered or to the quantity of practicing primary providers available. In this case, however, the number of full-time equivalent primary care providers was the same for both years. Thus, these data more likely reflect both an increase in consumer and provider awareness of the consequences of the disorder and an improvement in management techniques.

In summary, the results of the national efforts devoted to detecting and controlling high blood pressure can be evidenced on a local level as the majority of hypertensives in the five-county area, both black and white and male and female, are diagnosed, under treatment, and achieving a controlled blood pressure. The changes witnessed between 1972 and 1981 in the diagnostic and therapeutic status of hypertension in this locale reflect favorably on the impact that both consumer and provider education can have in attacking a public health problem. Increased specification of high risk groups can hopefully contribute to further improvement in the detection and control of high blood pressure as such individuals can be identified and targeted for special emphasis or specific program interventions. ★★

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Acknowledgement

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National High Blood Pressure Month ~ May 1983

Radiologic Seminar CCXXVIII: Acute Emphysematous Cholecystitis — A Case Report

RONALD P. SMITH, M.D. and
JAMES MORANO, M.D.
Jackson, Mississippi

AN 81-YEAR-OLD white man with diabetes mellitus and previous cerebral vascular accidents was referred for abdominal pain of unknown etiology. Upon arrival, he was noted to be markedly obtunded, had a tense, tender abdomen, and was found to have a marked leukocytosis. Abdominal radiographs were obtained which allowed the diagnosis of emphysematous cholecystitis. The characteristic findings of intramural and intraluminal gas are illustrated in this case.

Emphysematous cholecystitis is often, but not always, associated with cystic duct obstruction and occurs more frequently in males and in diabetics. The most common offending organism is *Clostridium welchii*, although *Escherichia coli*, *Klebsiella*, and anaerobic *Streptococci* are occasionally involved.¹ The clinical presentation is that of acute cholecystitis without specific features.² Early abdominal films may be normal. Later, intramural gas forms, finally followed by intraluminal gas.¹ Gallstones are present in approximately 50% of cases² and extension of gas into the biliary ducts is sometimes seen.¹ While the findings in this case are virtually diagnostic, the differential diagnosis of abnormal gas collections in the region of the gallbladder includes intrahepatic or perihepatic abscess, duodenal diverticulum, and cholecysto-enteric fistulas of either surgical or non-surgical origin.¹

Early surgical intervention was indicated in this patient since free perforation is present in 50 to 60% of cases;² an inflamed "foamy" gallbladder without stones or perforation was removed. The patient recovered uneventfully, although the presence of the emphysematous form of cholecystitis implies a higher morbidity and mortality on the average.² ★★★

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Figure 1. Magnified supine film of the right upper quadrant demonstrates gas within the gallbladder lumen and within the wall of the gallbladder. A nasogastric tube within the air-filled stomach is seen at the right upper corner, and air within colon is present along the lower edge of the film.

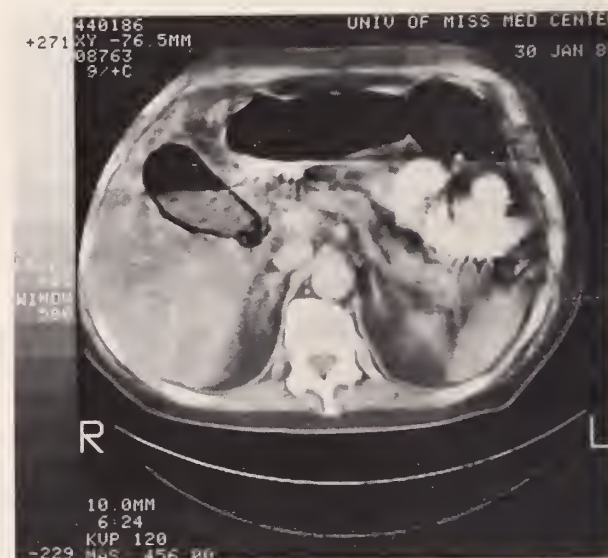


Figure 2. CT scan demonstrates a large gas-fluid level within gallbladder lumen. Gas is also seen within the wall of the gallbladder and extending into the proximal cystic duct.

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In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*

PROFILE

Leadership Is Family Tradition For Graves Brothers

PATSY SILVER

Two brothers, one a physician and the other an attorney, have the distinction of serving concurrently in the top leadership posts of their respective professional associations. No previous record of the unique accomplishment can be found in the history of the two organizations.

Dr. Sidney O. Graves of Natchez is president of the Mississippi State Medical Association, and his brother, Ernest W. Graves of Laurel, is incoming president-elect of the Mississippi State Bar. Both men are natives of Laurel.

The two have compiled long records of achievement and leadership in their professions.

Sidney Graves has served as chairman of the Mississippi State Medical Association's Board of Trustees. He is past president of the Mississippi Urological Association and of the Homochitto Valley Medical Society. He holds membership in the American Medical Association and the Southeastern Section of the American Urological Association. He attended Millsaps College and the University of Tennessee, where he received his M.D. degree. Following internship at Jefferson Davis Hospital in Houston, Texas, he completed residencies in urology and general surgery at Carraway Methodist Hospital in Birmingham, Alabama, and in urology at the

Dr. Sidney Graves and his brother, Ernest Graves, have the distinction of having been elected to the top leadership posts of the state's largest medical and legal professional associations.

University of Pennsylvania Hospital in Philadelphia. He has practiced medicine in Natchez since 1952.

Ernest Graves, a fellow of the American College of Trial Lawyers, is currently on the Lawyers Advisory Committee of the fifth Circuit Court of Appeals, and is immediate past president of the Mississippi Bar Foundation. He is a past president of the Mississippi Defense Lawyers Association, the Ole Miss Law Alumni Chapter, and the Jones County Bar Association, and he is a member of the American Bar Association and the International Association of Insurance Counsel. He attended Millsaps College, Northwestern University and the University of Mississippi, where he received his A.B. and LL.B. degrees. He has practiced law in Laurel since 1949.

Civic accomplishments are common to both men, as are professional dedication and recognition by their colleagues.



Sidney O. Graves, M.D.

Sidney Graves, a past president of the Natchez Rotary Club, was appointed by the Adams County Board of Supervisors to a term of service on the Board of Trustees of Jefferson Davis Hospital. He has also been a member of the Board of Trustees of Natchez Community Hospital. Following a day of recognition recently in his community, an editorial in the *Natchez Democrat* referred to Dr. Graves' long record of service as a community leader and noted that he had served in a number of civic roles. Dr. Graves currently is serving his second term on the Administrative Board of Jefferson Street Methodist Church.

Ernest Graves, past president of the Laurel Exchange Club, is also past chairman of the local chapter of the American Red Cross. He is past president of the Laurel Chamber of Commerce and former chairman of the administrative board of First United Methodist Church.

Sidney Graves and his wife, the former Marie Chalk of Meridian, have three children, Mrs. Charles Vess of Natchez, Mrs. Justin Comstock of Monterrey, California, and Sidney O. Graves, III, of Natchez. Ernest Graves and his wife, the former



Ernest W. Graves

Nancy Chenault of Houston, Mississippi, have a daughter, Mrs. William F. Goodman, III, of Jackson. The two men are the sons of Mrs. Sidney O. Graves, Sr., who still resides in Laurel.

Both men speak of the honor and challenge that accompanies election to such positions of leadership.

"The law, though less than perfect in its application, increasingly affects the rights of Americans, and it behooves attorneys and other citizens alike to improve our legal system which I believe now is vastly superior to any which exists in other parts of the world," Ernest Graves remarked. "In recent years the Mississippi State Bar has had a record of impressive accomplishments, and pleased am I to be a part of the leadership in our dynamic organization."

"I have observed the presidency of the Mississippi State Medical Association at close range for ten years," said Dr. Graves, "and I know well the men who have served during this period. Their contributions have been noteworthy to the growth of our association. I am honored to be the president and hope I have made a small addition to our organization."



The President Speaking

-30-

SIDNEY O. GRAVES, JR., M.D.
Natchez, Mississippi

Time certainly does get away from you. It is difficult for me to believe that this is the final "President's Page" that I will write. Some of my writing has been dry; some, I feel sure, has been uninteresting, but I do appreciate having the use of this space each month to express myself as I see fit.

In retrospect, I believe there are several subjects that I should have explored, but most of these are old hat, or else, too controversial to be worthwhile. In addition to that you are probably up to your ears already on such subjects as Over Utilization, Cost Containment, DRGs, Euthanasia, Abortion, etc., etc., ad infinitum. I will leave these subjects to be rehashed by my successors.

The one thing that I do want to say in this final page is *Thank You* for allowing me to be your president. It has been an interesting and enjoyable experience. Ree and I have covered the state and we have met with all the component societies to which we were invited, except one. That was missed because of an unexpected Washington trip during the FTC fight. We have seen many of our old friends, and have met new ones. Everywhere we went, we were treated royally. The cordiality of the component medical societies of the Mississippi State Medical Association is second to none. This is the part of my year that I value and appreciate the most. Again, thank you for your hospitality.

By the time you read this there will be a new president of the Mississippi State Medical Association. In the early 1970s he became involved in the activities of the association and he has remained deeply involved up to the present time. He is a very conscientious person and I can assure you that he will make an excellent president. Best of luck, Whit.

There are many people to whom I am beholden for the success of this year, but none more so than Charles Mathews and the staff of the Mississippi State Medical Association. You might be able to struggle through a year as president without their help, but you can be sure that it would be a nightmare. To this group, I also say, "many thanks."

In closing, let me repeat something I have said many times this year in speaking to the component medical societies. By becoming active participants in our professional association, each of us contributes to the well being of the profession and the public. We can thus insure that not only will our profession improve, but so will the public's perception of all of us as well. Let's all support our State Medical Association.

★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXIV, Number 5

MAY 1983

New Feature Invites Your Viewpoint on Issues

This issue introduces a special new feature called "Comment." For this column JOURNAL MSMA solicits comments from the membership on current medical practice issues.

If you have an idea, a suggestion, or just want to give your opinion about a current medical issue, write Comment, JOURNAL MSMA, Box 5229, Jackson, MS 39216. In the interest of space limitations, please try to keep your comment to 500 words or less.

It is hoped that there will be sufficient member participation in this feature to warrant its continuation. "Letters to the Editor" in newspapers and journals are frequently more widely read than editorials or any other features.

It was interesting to note that a recent column in the *Clarion Ledger* by Sidney Harris pertaining to Christians accepting "humanists" as political partners aroused so much comment and disclosed such divergent viewpoints.

Your JOURNAL can be a "forum" and can be much more interesting with the input of its membership. Your comments need not be scholarly treatises, nor even grammatically perfect. Our managing editor is quite capable of putting them in readable form if need be.

The JOURNAL must, of necessity, reserve the right to edit, but that will not likely be a factor of concern. When an idea strikes you, jot it down and send it in.

W. MONCURE DABNEY, M.D.
Editor

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

COMMENT

Physician or Agent — Which Are You?

The accumulation and retention of medical knowledge gleaned from early training in medical school and residency and later by experience in the practice of medicine is a never-ending but progressive process.

Much depends upon that foundation, formed in the early years of training by hard work, dedication and the conscientious application of sound principles of quality medical care. Too, the rapid progress and constantly changing events in meeting the challenges of medical care today, make it imperative that the physician keep abreast of the times by intensive study of medical problem cases and constantly adding to and building upon that early foundation with accumulated knowledge.

Cultivating good habits of study and applying good principles of care guided by sound medical knowledge gleaned from years of practice spells the difference between the successful practicing physician exercising sound medical judgment and the physician who acts merely as medical agent for his patients.

In which category do you belong?

Have you lost contact with your patients and the practice of medicine by diverting your attention and devoting a large part of your time to another business or sport?

Do you manage your practice in such a way that others do most of the work and thinking for you?

Is your success in practice of medicine based on financial gain rather than satisfaction of a job well done?

COMMENT / Continued

Do you allow your practice to manage you by attempting to attend an overwhelming number of patients, wherein a minimum amount of time and attention is devoted to each patient, doing an injustice to yourself and your patients?

Do you when admitting a patient to the hospital, "throw the book at them," by ordering a multitude of tests and procedures with little thought as to their indications?

Do you fail to study your patient's problem sufficiently to arrive at a reasonable differential diagnosis so as to direct further appropriate study and ancillary care?

Do you follow the practice of accumulating a vast number of tests and procedural reports in the hospital and then call in several consultants to unravel your problems rather than applying your knowledge to the problem and requesting only that consultant appropriate to assist you?

Do you admit patients before determining the need for hospitalization by thorough history, physical examination and rudimentary test available in the out-patient service?

Do you fail to give consideration to spending of your patient's money through unnecessary hospitalization and/or inappropriate ancillary care? Quality care is not necessarily the most expensive care and often times it may be just the reverse. Too, the threat of litigation should not be the answer.

If your answer to the above questions is in the affirmative, then you qualify as a "Medical Agent" in lieu of a practicing physician. You may be successful financially, but you will not enjoy the sense of satisfaction in your practice nor the admiration of your colleagues and peers.

So let's get along with the practice of medicine as a physician, delivering quality care. Your patients need and deserve it and you need to protect your image and reputation, and enjoy your self esteem.

J. T. DAVIS, M.D.

Medical Director

Miss. Foundation for Medical Care

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RECOLLECTIONS

In the May 1963 issue of JOURNAL MSMA, outgoing president Dr. C. P. Crenshaw, in his final "president's page" message, pledged his continuing support of the association. He also noted increasing assaults on the free choice, private system of medical care, and urged the membership to continue to preserve the system of medical care that had proved itself superior to any other in the world. "Let nothing deter our high aims and good purposes," he remarked, "Let us . . . continue to expand medical care in quality and quantity. Let us seek the best interest of the patient above all else. Let us be firm and uncompromising in our deep convictions."

News stories reported of two MSMA members who spoke at prestigious meetings: Dr. Lawrence Long, who addressed the North American Federation of the International College of Surgeons; and Dr. James D. Hardy, who delivered the William Mitchell Banks Memorial Lecture at England's University of Liverpool.

Scientific articles included: "The Pelvic Pressure Syndrome," by Dr. James L. Royals, of Jackson; "Bone and Joint Trauma Resulting from Automobile Accidents," by Dr. Griffin Bland of Gulfport; and "Pancoast or Superior Sulcus Tumor Syndrome," by Dr. Robert D. Sloan of Jackson.

LETTERS

SIRS: We have received a copy of the newsletter published by your professional association. We wish to express our appreciation for your assistance in passing this information to members of the Mississippi State Medical Association.

We believe that because of this effort, employers will be informed of the advantages of the On-the-Job Training program.

Again, thank you for your interest and assistance, and if this agency can be of assistance to you, please contact us.

Royal N. Gober

Employment Service Director

Mississippi State Employment Service

P.O. Box 1699

Jackson, MS 39205

MEDICAL ORGANIZATION

Dr. Weems Nominated for AMA Council on Medical Education

Dr. W. Lamar Weems of Jackson has been nominated by the American Medical Association's Board of Trustees for a post on the association's Council on Medical Education. Elections to fill vacancies in AMA offices will be held during the association's 132nd Annual Meeting next month in Chicago.

The announcement of his nomination marks the second time in as many months that Dr. Weems' name has appeared in the medical spotlight. In March he was installed as president of the Southeastern Section on the American Urological Association. He formerly served that organization as secretary and president-elect.

Dr. Weems is professor of surgery and director of the Division of Urology at the University of Mississippi Medical Center. He has been on the faculty of the UMC since 1965, and has been director of the Division of Urology since 1968. He is also chief of urology at the Jackson VA Medical Center.

A graduate of Millsaps College, Dr. Weems received his M.D. degree from Baylor College of Medicine. He completed his training in urology at the University of Mississippi and the Massachusetts General Hospital in Boston.

Dr. Weems is a fellow of the American College of Surgeons and holds membership in the American Urological Association, American Association of University Urologists, American Trauma Society, Mississippi Urological Society, the Society of Pelvic Surgeons and Southern Medical Association.

In 1981 the Mississippi State Medical Association presented Dr. Weems with the MSMA/Robins Award for Community Service in recognition of his many contributions to the education of deaf citizens in Mississippi and for outstanding service in other community and civic activities.

Dr. Weems has served as MSMA's delegate to the AMA since 1978. The AMA Council on Medical Education performs a number of functions relating to the study and evaluation of medical education programs for physicians and allied health personnel. The Council also reviews and recommends policies leading toward the AMA's provision of the highest



educational service to the public and the profession. The eleven-member Council also has the responsibility of recommending means by which the AMA may continue to provide information, leadership and direction to existing organizational bodies dealing with medical and allied health education.

Dr. Faser Triplett Named AMA Delegate by Allergists

The American College of Allergists has appointed Dr. R. Faser Triplett of Jackson as its representative to the American Medical Association's House of Delegates. He will assume the delegate's role next month at the AMA's 132nd Annual Meeting in Chicago.

Dr. Triplett, who recently announced his candidacy for the Mississippi state Senate (district 26), is immediate past president of the Mississippi State Medical Association. He formerly served as vice speaker and speaker of the MSMA House of Delegates.

A graduate of the University of Mississippi, Dr. Triplett received his M.D. degree from Tulane University School of Medicine. He is a clinical assistant professor of pediatrics at the University of Mississippi School of Medicine and is in the private practice of allergy. He has been associated with the Mississippi Allergy Clinic since 1966.

Dr. Triplett has served as president and chairman of the board of the Medical Assurance Company of Mississippi since its inception in 1976. He has also served on the board of directors of Gulf Guaranty Life Insurance Company, Avanti Travel, Inc., U & P Electric Company, and Mobile Communications Corp. of America.

Dr. Triplett is a member of the board of regents of the American College of Allergists. He is a fellow of the American College of Pediatrics and is a founder fellow and member of the board of governors of the American Association of Certified Allergists. He is past president of Southern Medical Association's Allergy Section.



Committee Announces Expansion of "CommuniCare"

The MSMA's patient inquiry program, CommuniCare, operating on a pilot basis since last October,

CommuniCare / Continued

has now been extended throughout the state. The announcement was made by Dr. James E. Waites of Laurel, chairman of the MSMA Committee on Peer Review, which governs operations of the program.

In all aspects — from the descriptive brochure to the handling of inquiries — CommuniCare stresses the importance of the physician-patient relationship. It also emphasizes the role good communications plays in preserving that relationship.

The public relations program was designed to serve as an additional vehicle for improving communications. CommuniCare was established under the direction of the MSMA Board of Trustees with approval of the House of Delegates. Lora Lane, R.N., is program coordinator.

In his statement announcing the expansion of the program, Dr. Waites pointed out that in a survey last year, MSMA members identified "better public communications" as the most pressing need of the profession. In a recent national survey, he added, 92% of physicians responding rated better physician-patient rapport as the most effective method for reducing the risk of a malpractice suit.

"Help us make CommuniCare a success by publicizing it in your office and by letting us know how you think the program can be improved," Dr. Waites remarked.

Members may obtain additional copies of the CommuniCare brochure for their offices by calling the MSMA headquarters office.

346 to Receive Degrees At UMC Commencement

The University of Mississippi Medical Center's 1983 Commencement is set for Sunday, May 29, at 4 p.m. in the Jackson City Auditorium.

Some 346 UMC students, including 138 School of Medicine students expect to receive degrees during the ceremony.

Dr. Robert Sparks, president of the Kellogg Foundation, will address this year's graduating group.

The Chancellor's reception, honoring graduates of the Schools of Medicine, Nursing, Health Related Professions, Dentistry and the graduate programs in the medical sciences, will precede the City Auditorium event. It's set for 1:45 p.m. on the health sciences campus.

UMC Hosts 10th Annual Surgical Forum in Jackson



Dr. Beckett Howorth, Jr., of Oxford, left, and Dr. Ross B. Love of Tupelo, were among the 221 surgeons from the United States who attended University of Mississippi Medical Center's 10th annual Surgical Forum. Only 19 of the paid registrants were newcomers. The remaining 202 were previous registrants, many of whom had attended for 10 consecutive years.

UMC Announces Faculty Appointments

The School of Medicine of the University of Mississippi Medical Center has added two new faculty members.

Dr. Norman C. Nelson, UMC vice chancellor for health affairs and School of Medicine dean, announced the appointments, following approval by the Board of Trustees, State Institutions of Higher Learning.

Ali Lavassani-Dana was named assistant professor of radiology. He received his undergraduate degree from Oklahoma State University and the M.S. degree from the Georgia Institute of Technology. Prior to coming to UMC, he was a radiation physicist at Memorial Medical Center in Corpus Christi, Texas. He also has been a medical physicist in cancer therapy at the Pahlavi Cancer Center in Tehran, Iran, and a health physics assistant and research assistant at Georgia Tech.

Dr. William Robert Smith was appointed instructor in medicine. He attended Millsaps College and earned the M.D. degree at UMC, where he also took his internship and residency. Dr. Smith has been in private practice in Texarkana, Texas, since July 1982.

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PERSONALS

ORLANDO ANDY of UMC presented a paper at the Southern Neurosurgical Society meeting in Sea Island, Georgia, in March.

ROBERT BALL of UMC was a program participant in the Louisiana/Mississippi regional meeting of the American College of Physicians in New Orleans in March.

WILLIAM BATES of UMC presented a paper at the recent meeting of the Society of Gynecological Investigation in Washington, DC.

KENDALL T. BLAKE of Jackson has been inducted as a fellow of the American Academy of Orthopaedic Surgeons.

ELDON BOLTON of Biloxi recently was honored by the Biloxi Regional Medical Center for his 50 years in the medical profession.

WALLACE CONERLY recently spoke at a meeting of the New Albany Rotary Club and was guest lecturer at Northeast Mississippi Junior College in Booneville.

DANIEL P. DARE of Vicksburg was recently inducted as a fellow of the American Academy of Orthopaedic Surgeons.

CLAUDE EARL FOX of Jackson was recently selected to serve on the Board of the Alan Guttmacher Institute.

STANLEY HARTNESS of Kosciusko has been recertified by the American Board of Family Practice.

WOOD HIATT of UMC recently spoke at a meeting of the Central PTA Council of the Jackson Public Schools.

JEFF HOLLINGSWORTH of Jackson spoke at a meeting of the Malabouchia Chapter of Professional Secretaries International (PSI).

PHIL A. HOOKER announces the opening of his office for the practice of allergy at 320 S. Gloster Street in Tupelo.

BECKETT HOWORTH of Jackson spoke at a recent meeting of the Jackson Audubon Society and also had an exhibition of his photographs of mountain ranges on display at the Mississippi Museum of Natural Science.

JAMES HUGHES of UMC was on the faculty for a continuing education course sponsored by the American Academy of Orthopaedic Surgeons in Anaheim, California.

HERBERT LANGFORD of UMC presented a paper at the 23rd annual Conference on Cardiovascular Disease in San Diego, California.

CONNIE MCCAA of UMC recently conducted a seminar at Mississippi State University in Starkville.

FRANK J. MORGAN of Jackson was recently elected to membership on the Federation Licensing Examination (FLEX) Board.

JOHN MORRISON of UMC was guest speaker at a seminar on perinatal medicine in Orlando, Florida.

NORMAN NELSON of UMC recently spoke at a meeting of the University of Mississippi Foundation board of directors and was a site visitor at the Academy of Health Sciences at Fort Sam Houston, and Baylor University graduate program in health care administration in San Antonio, Texas.

PHILIP O. NELSON has associated with Lakeland Radiologist of Jackson for the practice of radiology.

WILLIAM NICHOLAS of UMC recently was guest speaker at the Greenville chapter meeting of the Mississippi Affiliate of the American Diabetes Association and spoke to members of the medical staff at Mercy Hospital in Vicksburg.

RAY A. ST. ROMAIN has associated with the Woman's Clinic of Pascagoula for the practice of obstetrics and gynecology.

HARRY SCHMIDT of Biloxi recently was honored by the Biloxi Regional Medical Center for his 50 years in the medical profession.

W. COUPERY SHANDS of Jackson has been selected by the Jackson Chamber of Commerce as the Federal Handicapped Employee of the Year.

DAN THORNTON of Meridian was recently honored with a retirement reception at the Jeff Anderson Regional Medical Center.

MARY J. WARD of Tupelo announces the association of MARTA HANS in the practice of pediatrics and adolescent medicine.

ROY WILSON of UMC was recently elected chairman of the Southeastern University Departments of Anesthesiology Chairpersons at the group's annual meeting in Tampa, Florida.

Medico-Legal Brief

Suit Against Peer Committee Dismissed

A physician's action to recover for injuries allegedly resulting from a medical society peer review committee chairman's investigation should be dismissed, a federal trial court in New York ruled.

The chairman received letters from insurance companies complaining about certain fees charged by the physician for endo-sinal and endo-nasal surgery. The committee undertook an investigation not only of the fees charged but also of the propriety of the physician's medical procedures.

The chairman wrote letters to various educational institutions and other third parties requesting evaluation of the physician's medical procedures. Several responses were mildly to severely critical of the physician's charges and surgical procedures. The committee communicated fee recommendations to the insurance companies and informed the physician of its activities. The chairman informed the physician by letter that the committee's determination had been substantially unfavorable to him.

The physician brought an action against the chairman, alleging that his investigation went beyond any legitimate necessity and therefore must have been primarily motivated by personal malice toward him.

He contended that the investigation caused him acute emotional distress, severely damaged his professional reputation, and compelled him to incur legal fees.

The court said that the physician failed to show any evidence of severe emotional distress. He claimed merely that he suffered minor loss of sleep and restlessness over a short period. As to any effect on his practice, the physician did not claim to have curtailed his surgery schedule and identified no patients who stopped seeing him or physicians who stopped referring patients to him because of the committee's actions.

The physician also claimed libel on the basis of the letter written to him by the chairman. The letter stated that a number of the physician's patients had not had a satisfactory result on the basis of follow-up experience of other physicians. It was dictated to the society's executive secretary, who had attended all meetings of the peer review committee, and it supposedly was seen by no other person.

The court found that the chairman had exhibited scrupulous restraint in confining publication of the alleged libel to the physician and that malice could not be established on the record. The court dismissed the complaint. — *Greenfield v. Kanwit*, 546 F.Supp. 220 (D.C., N.Y., Aug. 4, 1982)

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NEW MEMBERS

BARNES, JOHN R., Vicksburg. Born Vicksburg, MS, Oct. 6, 1952; M.D., Louisiana State University School of Medicine, New Orleans, May 1977; family practice residency, University of Alabama, 1977-80; elected by West Mississippi Medical Society.

ELMORE, THOMAS D., Amory. Born Little Rock, AR, Feb. 27, 1949; M.D., University of Tennessee Center for Health Sciences, Memphis, 1978; interned City of Memphis Hospitals, one year; ob-gyn residency, University of Tennessee, 1979-82; elected by Northeast Mississippi Medical Society.

HARRISON, ROBERT EARL, Biloxi. Born Chinkiang, China, March 10, 1923; M.D., University of Michigan Medical School, Ann Arbor, 1946; interned St. Luke's Hospital, Bethlehem, PA, one year; elected by Coast Counties Medical Society.

LIBERTO, VINCENT, Jackson. Born Grenada, MS, March 8, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned and

psychiatry residency, University Medical Center, Jackson, 1974-77; elected by Central Medical Society.

MELVIN, CHARLES W., Columbus. Born Florence, AL, March 27, 1953; M.D., University of Alabama School of Medicine, Birmingham, 1979; interned Baylor Affiliated Hospitals, Houston, one year; pediatrics residency, same, 1980-82; elected by Prairie Medical Society.

SAVAGE, PATRICK J., Keesler AFB, MS. Born Detroit, MI, Jan. 21, 1949; M.D., Medical College of Virginia, Commonwealth University School of Medicine, Richmond, 1975; interned USAF Medical Center, Scott AFB, IL, one year; internal medicine residency, USAF Medical Center Keesler AFB, MS, 1976-79; pulmonary medicine residency, Wilford Hall Medical Center, Lackland, TX, 1979-81; elected by Coast Counties Medical Society.

TIPTON, RAYMOND E., JR., Jackson. Born New Orleans, LA, Dec. 1, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned University South Alabama Medical Center, Mobile, one year; radiology residency, UMC, Jackson, MS, 1981-84; elected by Central Medical Society.

WILLIAMS, JOHN E., Gulfport. Born Jackson, MS, Dec. 26, 1934; M.D., University of Mississippi School of Medicine, Jackson, 1961; interned University Medical Center, Jackson, one year; general surgery residency, Naval Hospital, St. Albans, 1964-68; elected by Coast Counties Medical Society.

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DEATHS

CHAMPION, JAMES T., Meridian. Born Woodland, MS, April 23, 1915; M.D., University of Tennessee School of Medicine, Memphis, 1954; interned Baptist Hospital, Jackson, MS, one year; internal medicine residency, University Medical Center, Jackson, MS, one year; died Dec. 9, 1982, age 67.

CLARK, LAURANCE J., JR., Jackson. Born Oct. 9, 1928; M.D., University of Mississippi School of Medicine, Jackson, 1960; interned Tampa General Hospital, Tampa, FL, one year; medicine residency, Confederate Memorial Hospital, Shreveport, 1961-62, University Medical Center, Jackson, MS, 1962-64; died March 8, 1983, age 54.

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SOLVING THE MYSTERY OF PASCAGOULA

More than 20 years ago, a combined demonstration of medical science and community effort turned an outbreak of infectious hepatitis in Mississippi into a national landmark of disease prevention.¹

When health officials in Pascagoula, Mississippi, reported more than a dozen cases of hepatitis, the Communicable Disease Center in Atlanta assigned an epidemiologist to aid local efforts in tracing the origin of the infection.

Nurses on duty at the Jackson County Health Clinic and physicians at Singing River Hospital were interviewed, as were the patients themselves. It soon became clear that the patients had not shared a meal, had not frequented the same restaurant and had not been together in any of the most likely sites for contamination. However, a startling fact did come to light... each of the 13 infected patients had eaten raw oysters within the previous two months.

Checking and double-checking the clues...

Raw oysters were a common food in Pascagoula, but at that time shellfish were not known to cause hepatitis. As a control, 13 names were selected from the city's

telephone book. Each person questioned denied having eaten oysters, and none had symptoms of hepatitis. The investigation was narrowing down, but there was still much probing to be done.

...to find the cause

With the assistance of a sanitation engineer and a shellfish expert, the investigators began the tedious task of inspecting the local stores, oyster plants, packagers and shucking companies. Finally, they found the source of the infections: an oyster bed at the mouth of the Pascagoula River, ordered closed to oystering some 30 years earlier because it was polluted.

The diligent work of 20 specialists—epidemiologists, virologists, bacteriologists, internists, pediatricians and public health officers—had led to an awareness of shellfish as potential hepatitis carriers, and to the need for closely regulating both shellfishing and water pollution protections. The work done in Pascagoula stands as a remarkable joint effort in the history of modern medicine in the United States.

Reference: 1. An era of specialists, chap. 5, in Lee RV, Eimerl S *et al.* *The Physician*. New York, Life Science Library, Time Inc., 1967, pp. 107-109



When the history reveals anxious depression...

For the estimated 70 percent of nonpsychotic depressed patients who are also anxious,¹ Limbitrol provides both amitriptyline, specific for symptoms of depression, and the effects of Librium® (chlordiazepoxide HCl), the tested and dependable anxiolytic. Limbitrol is, therefore, a better choice for these patients than dual agents that contain a phenothiazine, a class of antipsychotic drugs used infrequently in nonpsychotic patients.¹

62% of Overall Improvement...Within the First Week

Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.²

In another multicenter study,³ the following symptoms associated with anxious depression were significantly reduced during the first two weeks of therapy:

- ☐ Headache—79%
- ☐ Early insomnia—91%
- Middle insomnia—87%
- Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.³

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jarvik ME; New York, Appleton-Century-Crafts, 1977, p. 316. 2. Feighner JP *et al*: *Psychopharmacology* 61:217-229, Mar 1979. 3. Data on file, Hoffmann-La Roche Inc., Nutley, NJ

In moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline
(as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline
(as the hydrochloride salt)

Please see summary of product information on following page.

LIMBITROL® TABLETS® Tronquizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief at moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use at this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those at barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated. Sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50

POSTGRADUATE CALENDAR

May 20-May 22

ADVANCED CARDIAC LIFE SUPPORT PROVIDER
COURSE

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Anesthesiology, the School of Nursing, the UMC Division of Continuing Health Professional Education, and the American Heart Association, Mississippi Affiliate.

Course director: Dr. George D. Lyon, instructor in anesthesiology.

The purpose of the course is to train and certify health professionals in ACLS as defined by the American Heart Association. Registrant will spend five hours in skills practice laboratory. Fee: \$175. Credit: 16 hours AMA Category I. American College of Emergency Physicians, and American Academy of Family Practitioners.

June 3-4

OPHTHALMOLOGY UPDATE

Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery Division of Ophthalmology and the UMC Division of Continuing Health Professional Education. The program has been funded in part by the Allergan and the Dameron Friley Spruill and Wilma Zay Spruill Lectures in Ophthalmology Fund provided by Fay Spruill Davidson, L. Stacy Davidson, Jr., M.D., John Stacy Davidson and Friley Spruill Davidson.

Coordinator: Dr. Ching J. Chen

This conference covers the latest developments in surgery and treatment of diseases of the eye. Topics include YAG laser surgery, implant surgery, macular diseases, retinal diseases, and pediatric ophthalmological practice. Fee: \$100. Credit: 8 hours AMA Category I.



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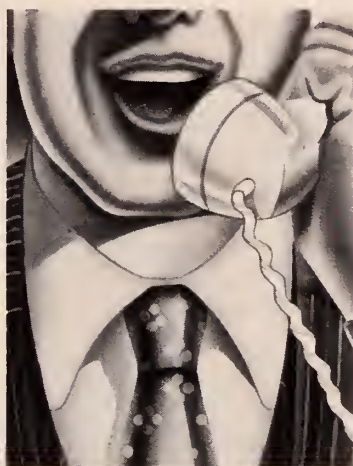
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PATHOLOGIST-ONCOLOGIST seeks practice location. Frank P. Urso, M.D., P. O. Box 1149, Akron, OH 44301.

FAMILY PRACTICE resident seeks practice location in July 1983. Contact John D. Sites, M.D., 2002 Philip Dr., Muncie, IN 47302.

ANESTHESIOLOGIST seeks to relocate in state in solo, group or institutional practice. Contact M. T. Olivo, Jr., M.D., Box 794, Oxford, MS 38655.

SURGEON seeks location with established group in small city. Currently service as chief surgical resident at Ochsner Foundation Hospital. Available July 1983. Contact Thomas C. Kelly, M.D., 1516 Jefferson Highway, New Orleans, LA 70121.

PEDIATRICIAN seeks practice location in central or Gulf Coast area upon completion of residency in July 1983. Contact Steven D. Eggen, M.D., Alton Ochsner Medical Foundation, 1516 Jefferson Highway, New Orleans, LA 70121.

PATHOLOGIST seeks position in community hospital setting upon completion of residency in June 1983. Contact Robert J. Sinnenberg, M.D., Box 662 MCV Station, Medical College of Virginia, Richmond, VA 23298.

PHYSICIAN seeks ER position. Available July 1983. Contact Earl P. Wright, M.D., 218 Ternwing Dr., Arnold, MD 21012.

OTOLARYNGOLOGIST currently doing fellowship in facial plastic and reconstructive surgery. Seeks partnership or group practice in Gulf Coast area. Contact J. L. Autin, M.D., 1516 20th St. South, Birmingham, AL 35205.

Physicians Wanted

FAMILY PRACTITIONER wanted to locate in East Central Mississippi community, population 1,000 with trade area of 10,000. Clinic will be provided if desired. Contact Sandersville Health Care Services, Inc., Drawer C, Sandersville, MS 39477.

FAMILY PRACTITIONERS. Excellent private practice opportunity, well equipped 30-bed hospital in operation less than two years. Office space available in renovated clinic, 100-bed nursing home, nice community, good schools and recreational facilities, located 30 miles east of Jackson. Call (601) 732-6252 or write A. B. Farris, Jr., Mayor, P. O. Drawer 338, Morton, MS 39117.

FAMILY PHYSICIAN wanted to locate in small town in central Mississippi. Excellent private practice opportunity. Large trade area. Established clinic with all equipment, including x-ray. Call (601) 253-2321. Mayor Grady Sims, Walnut Grove, MS 39189.

FAMILY PRACTITIONER for historic Vaiden, MS. Population 1,000 with outlying area of 1,200. Located on I-55 between Jackson, MS and Memphis, TN. Ideal free office adjoining dental clinic. Our beloved physician retired. Lucrative practice, no competition; outstanding hospital (10 miles). Friendly community; fine public schools; family-like churches. Excellent housing; low taxes; hunting, fishing and trapping galore. For more details call (601) 464-8884 or write John C. Coleman, Mayor, P.O. Box 76, Vaiden, MS 39176.

FAMILY PRACTITIONER, surgeon and ob-gyn to locate with established practice in south Mississippi. Salary negotiable, partnership arrangement. Write Box A-115, Journal MSMA, P.O. Box 5229, Jackson, MS 39216.

NOTICE

INTERNS, RESIDENTS, ANY PHYSICIAN LICENSED TO PRACTICE MEDICINE IN MISSISSIPPI

Positions for part-time medical consultants are now available at the Disability Determination Services of Mississippi. The pay and hours are good. Interns and residents wanting to interrupt their training programs for a year or more are welcome to apply. If interested, call 922-6811, ext. 2277 (Dr. John Barr) or ext. 2000 (Mr. John Cook).

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BARGAIN SALE. Burroughs L-9000 Computer. Like new. Designed for use in medical practice, especially groups. Am selling because I no longer need it in my practice. Contact Dr. R. W. Browning, M.D., 1317 River Rd., Greenwood, MS 38930; (601) 453-4060.

Next Month in JOURNAL MSMA

Complete Report of the 115th Annual Session

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IN CONCLUSION

Stroke deaths in the U.S. have declined 42% during the past 10 years, and that is in part the result of a successful national effort to control high blood pressure, according to Dr. Robert I. Levy, chairman of the 1983 National Conference on High Blood Pressure Control last month in Washington. Public awareness of the dangers of high blood pressure increased from 57% to 73% between 1973 and 1979, Dr. Levy said. Stroke remains one of the costliest diseases in the U.S., however, accounting for \$1.2 billion in hospital costs alone.

New data gathering techniques developed at the New York State Department of Public Health support previous studies showing that birth defect rates for fetuses of would-be mothers who are 45 years old are ten times higher than the rates seen for fetuses of 35-year-old women. That was reported in the April 15 issue of JAMA. The authors said the chance of a 35-year-old woman having a live born child with a chromosomal abnormality is 5.0 per 1,000 births; at age 45 the risk spirals upward to 50.0 for every 1,000 births.

More than 350,000 Patient Medication Instruction (PMI) pads have been distributed to physicians since the first 20 titles were released last October. Office-based physicians ordered more than 90% of the pads. Twenty new PMI titles are now ready for distribution, and may be ordered from the PMI Order Dept., AMA, P.O. Box 52, Rolling Meadows, IL 60008. Pennwalt Corp. is the latest contributor to the AMA Education and Research Foundation that finances the PMI program. To date, contributions total nearly \$2 million.

The AMA's public image has not been damaged by its FTC campaign, according to recent surveys. Despite the controversy, the public's trust and confidence in the association increased from 70% to 72% in the last two years, while trust and confidence in the federal government decreased from 53% to 43%. The survey found strong public support for local medical organizations to review complaints of high fees, set standards for physicians' performance and education, and to develop maximum limits for physicians' fees to help keep down medical costs.

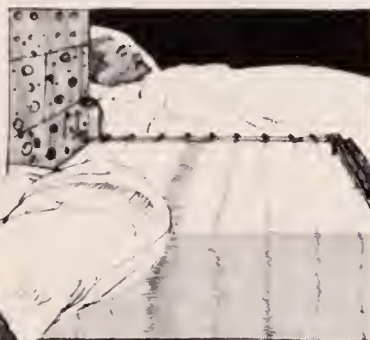
There were 192,583 primary care physicians in 1981, according to figures from the AMA Physician Masterfile. They represented 44% of practicing physicians, and by percentage were distributed among the following specialties: internal medicine, 17.5%; family practice, 7.2%; pediatrics, 6.9%; general practice, 6.8%; and obstetrics/gynecology, 6.3%. The largest number of resident physicians in 1981 specialized in internal medicine (15,542), general surgery (8,272), and family practice (5,316).

The weight of objective evidence supports the clinical efficacy of Dalmane®

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- Studied in over 200 clinical trials involving over 10,000 patients.¹³
- During long-term therapy, which is seldom required, periodic blood, kidney and liver function tests should be performed.
- Contraindicated in patients who are pregnant or hypersensitive to flurazepam.
- Caution patients about drinking alcohol, driving or operating hazardous machinery during therapy.



References: 1. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 4. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 5. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Kales JD: *Pharmacol Physicians* 4:1-6, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5:25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The

sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. **Adults:** 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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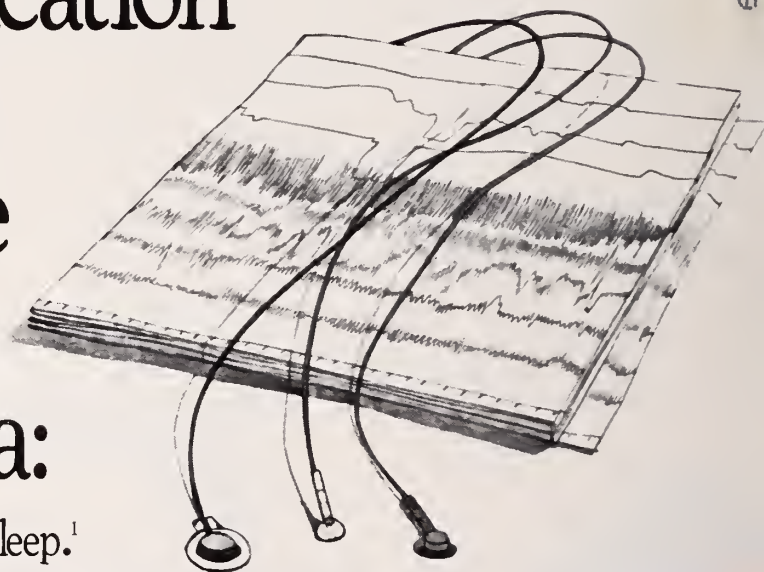
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Please see summary of product information on reverse side.

June 1983

JOURNAL of the **MISSISSIPPI** State Medical Association



Whitman B. Johnson, Jr., M.D. — MSMA President, 1983-84

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June 1983, Volume XXIV, Number 6

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Roche salutes
the history of Mississippi medicine



SOLVING THE MYSTERY OF PASCAGOULA

More than 20 years ago, a combined demonstration of medical science and community effort turned an outbreak of infectious hepatitis in Mississippi into a national landmark of disease prevention.¹

When health officials in Pascagoula, Mississippi, reported more than a dozen cases of hepatitis, the Communicable Disease Center in Atlanta assigned an epidemiologist to aid local efforts in tracing the origin of the infection.

Nurses on duty at the Jackson County Health Clinic and physicians at Singing River Hospital were interviewed, as were the patients themselves. It soon became clear that the patients had not shared a meal, had not frequented the same restaurant and had not been together in any of the most likely sites for contamination. However, a startling fact did come to light... each of the 13 infected patients had eaten raw oysters within the previous two months.

Checking and double-checking the clues...

Raw oysters were a common food in Pascagoula, but at that time shellfish were not known to cause hepatitis. As a control, 13 names were selected from the city's

telephone book. Each person questioned denied having eaten oysters, and none had symptoms of hepatitis. The investigation was narrowing down, but there was still much probing to be done.

...to find the cause

With the assistance of a sanitation engineer and a shellfish expert, the investigators began the tedious task of inspecting the local stores, oyster plants, packagers and shucking companies. Finally, they found the source of the infections: an oyster bed at the mouth of the Pascagoula River, ordered closed to oystering some 30 years earlier because it was polluted.

The diligent work of 20 specialists—epidemiologists, virologists, bacteriologists, internists, pediatricians and public health officers—had led to an awareness of shellfish as potential hepatitis carriers, and to the need for closely regulating both shellfishing and water pollution protections. The work done in Pascagoula stands as a remarkable joint effort in the history of modern medicine in the United States.

Reference: 1. An era of specialists, chap. 5, in Lee RV, Eimerl S *et al*: *The Physician*. New York, Life Science Library, Time Inc., 1967, pp 107-109



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62% of Overall Improvement...Within the First Week

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- Late insomnia—89%
- ☐ Gastrointestinal upset—73%

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In moderate depression and anxiety

Limbitrol®

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Please see summary of product information on following page.

LIMBITROL® TABLETS® Tronquillizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage at three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, Prescription Paks of 50.

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Many patients presented with physical symptoms are suffering from psychiatric illness, but are unaware of it. And while not all who suffer from mental illness or emotional problems need hospital treatment, hospitalization may be essential to provide a therapeutic environment in which the patient can effectively deal with his or her problems.

Riverside Hospital is a 56-bed, short-term care facility which provides intensive treatment of patients suffering from psychiatric illnesses, alcoholism, and drug dependencies. In Riverside's open, non-institutional environment, traditional and new, progressive psychotherapies are utilized.

Above all, care at Riverside is aimed at treating the patient with respect and dignity, fostering self-esteem, and returning the patient to independence and a satisfying, productive and happy life.

Riverside is licensed by the Mississippi Commission on Hospital Care, and is fully accredited by the Joint Commission on Accreditation of Hospitals.

The medical staff includes a large number of psychiatrists in private practice in the Jackson area. A toll-free number, 1-800-962-2180, has been established at the hospital for referral service to physicians on the active medical staff.

Physicians who have patients who would benefit from the type of treatment approach offered by Riverside may obtain referral information by contacting the Director of Admissions.

 Riverside Hospital

P. O. Box 4297, Jackson, Mississippi 39216

Telephone: (601) 939-9030

Incoming Mississippi WATS: 800-962-2180

NEWSLETTER

June 1983

Dear Doctor:

A House-Senate conference committee is expected to meet early this month to consider legislation providing health care for the unemployed. Late last month the House Energy and Commerce Committee reported HR 3021 to the full House. The bill, entitled the "Health Care for the Unemployed Act," would provide health benefits for certain unemployed persons and their families at an estimated cost of \$2.6 billion in FY 1984.

Physicians have responded to the needs of those who have lost jobs and health insurance coverage - with 71% providing free care or reduced fees for those persons, according to the AMA Socioeconomic Monitoring System. Also, 55% are doing the same for those who have lost Medicaid coverage due to cutbacks in the program.

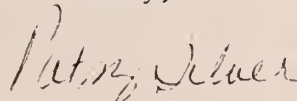
President Reagan recently praised medical society leaders and others who have initiated and supported voluntary efforts to provide free and low-cost care to jobless people. He reiterated his support of private-sector action during a meeting commemorating National Volunteer Week.

The issue of medical treatment for severely impaired newborns continues to receive attention. The HHS "Baby Doe" regulation was struck down in federal court recently, but Congress and state legislatures continue to examine the issue. Different versions of the regulation are appearing as provisions in various legislative bills across the country.

Concern about governmental interference into medical practice was cited by the AMA as a basis for its objections to a proposed constitutional amendment authorizing federal and state governments to restrict or prohibit abortions. If the amendment were adopted, the AMA told a Senate sub-committee, "women could potentially be denied a necessary medical procedure."

The Poison Control Center at the University of Mississippi Medical Center is once again available to the public by telephone 24 hours a day, seven days a week. Poison information specialists staff the center round-the-clock for help in poisoning emergencies. The number is 354-7660.

Sincerely,



Patsy Silver
Managing Editor

MID-SOUTH TRANSCRIPTION CENTER

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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kramer MJ, Mauriz YR, Robertson TL, Timmes MD: Morphological studies on the effect of subinhibitory and inhibitory doses of sulfamethoxazole-trimethoprim combination on *Escherichia coli*. Presented at the 12th International Congress of Chemotherapy, Florence, Italy, Jul 19-24, 1981. 3. Spicehandler J et al: *Rev Infect Dis* 4:562-565, Mar-Apr 1982. 4. Stamey TA: *Pathogenesis and Treatment of Urinary Tract Infections*. Baltimore, Williams & Wilkins, 1980, p. 13. 5. Ronald AR: *Clin Ther* 3:176-189, Mar 1980. 6. Cooper J, Brumfitt W, Hamilton-Miller JMT: *J Antimicrob Chemother* 6:231-239, 1980. 7. Gower PE, Tasker PRW: *Br Med J* 1:684-686, Mar 20, 1976. 8. Cosgrove MD, Morrow JW: *J Urol* 111:670-672, May 1974. 9. Irvani A et al: *Antimicrob Agents Chemother* 19:598-604, Apr 1981. 10. Schaeffer AJ, Flynn S, Jones J: *J Urol* 125:825-827, Jun 1981. 11. Rous SN: *J Urol* 125:228-229, Feb 1981. 12. BAC-DATA Medical Information Systems, Inc., Bacteriologic Reports, Winter Series, 1976-82.

Bactrim® DS

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients. **Pregnancy:** Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age. URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per tea spoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).



ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
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In vitro studies demonstrate



Bactericidal activity

with minimal resistance

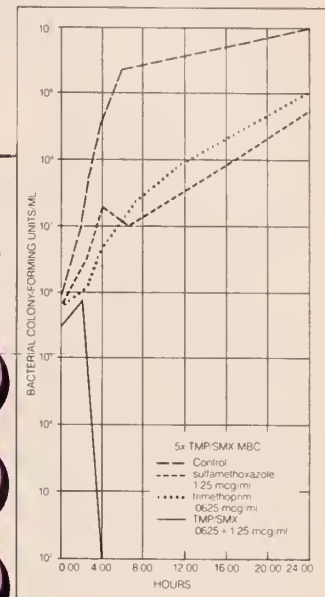
Percent of isolates of common uropathogens sensitive to BACTRIM and to other antimicrobials



[†]Analogous to cephalothin, the primary antibiotic disc used in testing

Source: The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter Series, 1981-82.
Numbers under percentages refer to the projected number of isolates tested.

RAPID IN VITRO DESTRUCTION
OF *E. COLI*^{*}



Kill curve kinetics of Bactrim and its individual components against *E. coli* in vitro.¹

The bactericidal action of Bactrim has been demonstrated *in vitro* on laboratory strains of *E. coli*^{1,2} and on clinical isolates of *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and *Morganella morganii*³—the most common causative organisms of urinary tract infections.⁴ More than 100 published studies attest to the efficacy of Bactrim in recurrent urinary tract infections due to these organisms.⁵ In comparative studies with other antimicrobials, Bactrim has consistently demonstrated unsurpassed efficacy during therapy.^{6,11}

Resistance to Bactrim develops more slowly than to either of its components alone *in vitro*.^{*} Among urinary tract isolates, resistance has rarely emerged in susceptible strains.^{5,12} Bactrim is contraindicated in pregnancy at term, during lactation, in infants less than two months old and in documented megaloblastic anemia due to folate deficiency. Initial episodes of uncomplicated urinary infections should be treated with a single-agent antimicrobial.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

b.i.d. for recurrent urinary tract infections

^{*}*In vitro* data do not necessarily predict clinical results.

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DATELINE

Wildlife Rabies On the Increase

Jackson, MS - The health department says Mississippi may soon experience an increase in wildlife rabies as severe as that reported in surrounding states, where rabies has increased significantly in bats, skunks, foxes and raccoons. In 1982 Mississippi had 13 reported cases, all in bats. That total was an increase over the previous few years. Last year there were 356 cases in Tennessee, 157 in Arkansas, 145 in Alabama, and 32 in Louisiana.

Report Side Effects Of HBV Vaccine

Jackson, MS - Physicians are urged to report to the State Health Department's Office of Epidemiology all episodes of significant side effects to hepatitis B virus (HBV) vaccine. The Center for Disease Control is serving as a clearinghouse for reports of side effects. Since June 1982, when the vaccine was first marketed, an estimated 800,000 doses have been distributed in the U.S. The CDC is investigating several reports of serious side effects.

Breast Cancer Treatment Alternative Studied

Chicago, IL - A large scale study by surgeons and physicians at M.D. Anderson Hospital suggests that conservative surgery and irradiation are viable alternatives to radical mastectomy for selected patients with early breast cancer. A study of 922 patients, reported in the May issue of Archives of Surgery, showed disease-free survival rates at five and ten years similar to rates for radical mastectomy for minimal, stage I and stage II breast cancer.

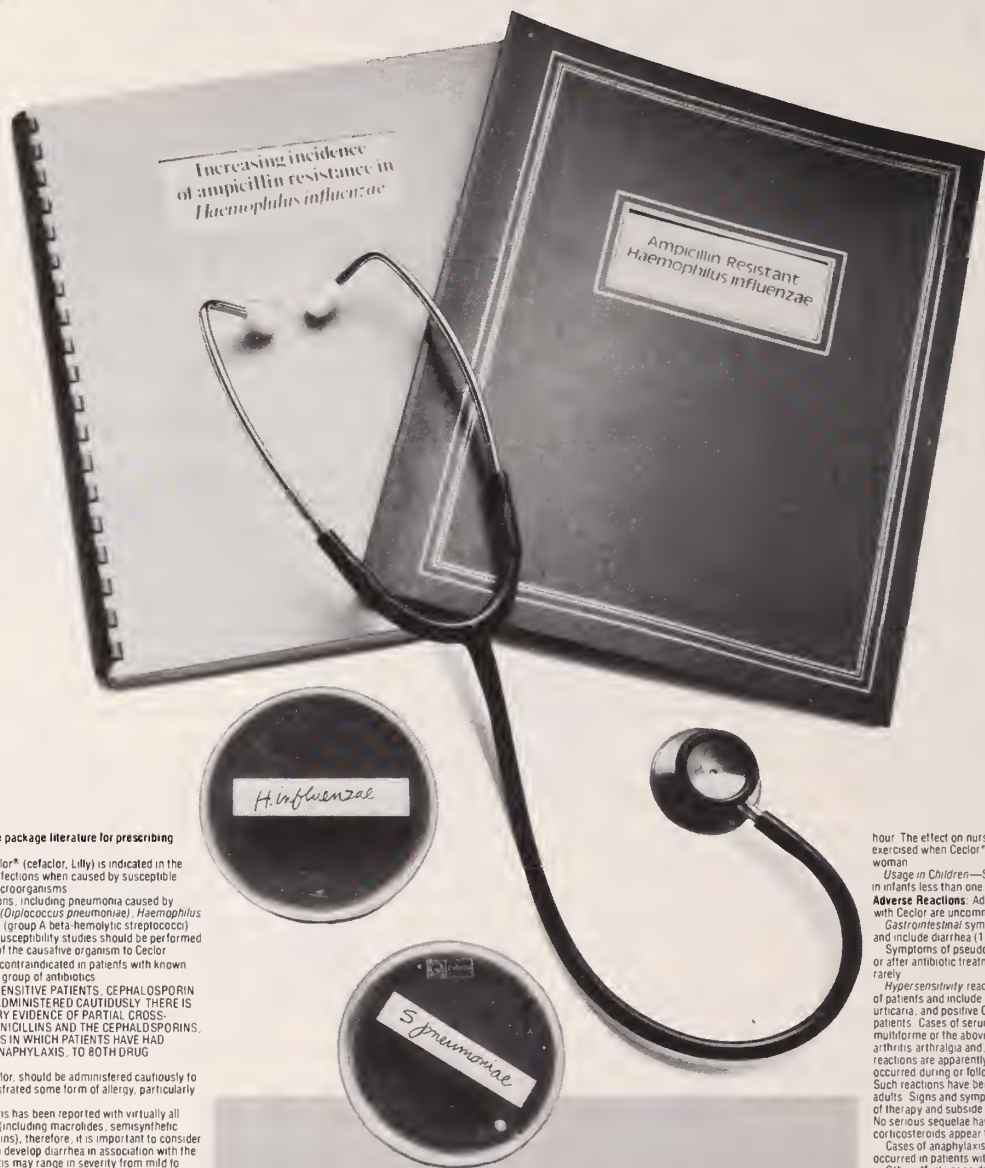
More States Enact Child Restraint Laws

Jackson, MS - Mississippi's new child restraint law becomes effective July 1. The law requires infants under two years of age to be in an appropriate child restraint safety device whenever they are passengers in a motor vehicle. Thus far this year fifteen states have enacted child restraint legislation, bringing to 35 the total number of states across the country with such child protection laws.

New Measles Vaccine Reported Successful

Chicago, IL - An aerosolized measles vaccine which was 100% effective even in children under one year of age now makes possible mass immunization programs throughout the world. The vaccine holds special promise for controlling measles in countries where other immunization projects are inadequate, according to Dr. Albert Sabin and his colleagues, who report on the first clinical trial of the vaccine in the May 20 issue of JAMA.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary Consult the package literature for prescribing information

Indications and Usage: Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: General Precautions—If an allergic reaction to Cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporins. In hematologic studies or in transfusion cross-matching procedures, when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cefclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Cefclor have been detected in mother's milk following administration of single 500-mg doses.

Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours, respectively. Trace amounts were detected at one

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

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hour. The effect on nursing infants is not known. Caution should be exercised when Cefclor® (cefclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Cefclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70). Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome. Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transient abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematologic—Transient fluctuations in leukocyte count predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

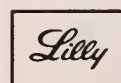
Note: Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Cefclor is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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DESCRIPTION: Each tablet contains 200 mg meprobamate and 325 mg aspirin.

INDICATIONS: Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease. Clinical trials demonstrated in these situations relief of pain is somewhat greater than with aspirin alone. Effectiveness in long-term use, i.e. over 4 months, has not been assessed by systematic clinical studies. Physicians should periodically reassess usefulness of drug for individual patients.

CONTRAINDICATIONS: ASPIRIN: Allergic or idiosyncratic reactions to aspirin or related compounds. MEPROBAMATE: Acute intermittent porphyria, allergic or idiosyncratic reactions to meprobamate or related compounds, e.g. carisoprodol, meprobamate, or carbamadol.

WARNINGS: ASPIRIN: Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants. In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes.

MEPROBAMATE: DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred. Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo; therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e.g. anxiety, anorexia, or insomnia, or withdrawal reactions, e.g. vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinations, and, rarely, convulsive seizures. Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders. Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation; symptoms usually cease

within next 12-to-48-hour period. When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly. Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS: Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e.g. driving or operating machinery.

ADDITIVE EFFECTS: Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chloralhydrate, and diazepam) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate possesses the placental barrier. It is present both in umbilical cord blood of or near maternal plasma levels and in breast milk of lactating mothers of concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN: Keep preparations with aspirin out of reach of children. Equagesic-M is not recommended for patients 12 years of age and under.

PRECAUTIONS: ASPIRIN: Salicylates an-

tagonize uncoupling activity of probenecid and sulfinpyrazone. Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE: Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney; to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies.

ADVERSE REACTIONS: ASPIRIN: May cause epigastric discomfort, nausea, and vomiting. Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur. Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE: CNS: Drowsiness, hypotensive crisis. GI: Nausea, vomiting, diarrhea. CARDIOVASCULAR: Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, pelecchia, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross sensitivity between meprobamate, meprobamate and meprobamate/carbamadol. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis. Stevens-Johnson syndrome and

bullous dermatitis have occurred.

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura.

OTHER: Exacerbation of porphyric symptoms.

DOSE AND ADMINISTRATION: Usual dose is one or two tablets 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under.

OVERDOSAGE: Treatment is essentially symptomatic and supportive. Any drug remaining in the stomach should be removed by induction of vomiting or gastric lavage may be indicated. Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoadosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions. Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported. Acute simple overdose (meprobamate alone): Death has been reported with ingestion of as little as 12 gram meprobamate and survival with as much as 40 gram.

BLOOD LEVELS: 0.5-2.0 mg percent represents usual blood-level range after therapeutic doses. The level may occasionally be as high as 3.0 mg percent usually 3-10 mg percent usually corresponds to

findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma. 10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur. At levels greater than 20 mg percent, more fatalities than survivals can be expected.

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator.

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated. Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate. Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration. Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption.

HOW SUPPLIED: Bottles of 50 scored tablets.

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ORIGINAL PAPERS

Pulmonary Malignancy in a 21-Year-Old Male With Progressive Systemic Sclerosis

CHRIS H. BENSON, M.D., WILLIAM C. PINKSTON, M.D., JILL WOODLIFF, M.D.,
and VALEE HARISDANGKUL, M.D.

Jackson, Mississippi

THE DEVELOPMENT of primary pulmonary malignancies in patients with progressive systemic sclerosis (PSS) was first described in 1953.¹ Since then over 50 cases have been described in the literature.

Several recent reviews emphasize that most tumors are of broncho-alveolar cell or adenocarcinoma cell type.^{2, 3} Evidence of underlying interstitial fibrosis is often present and most cases occur in patients with long-standing PSS.

We report a case of malignant pleural and parenchymal pulmonary disease that developed in a 21-year-old black man with a long-standing history of PSS. We believe this to be the youngest patient to develop this complication.

Case Report

A 21-year-old black male non-smoker with a 14-year history of PSS was admitted to the hospital complaining of increasing dyspnea.

The diagnosis of PSS had been based on the presence of diffuse thickening of the skin of the hands, face, chest and legs, symptoms of Raynaud's phenomenon, acro-osteolysis of the digits, and esophageal motility dysfunction. His course had been complicated by recurrent malleolar and digital ulcerations. Previous chest radiographs and pulmo-

nary function testing had been consistent with interstitial lung disease. There was no history of myositis, hypertension or renal disease.

Six weeks prior to admission he developed fever, chills, pleurisy, a non-productive cough without hemoptysis, and a pulmonary infiltrate in the left lower lobe. Intravenous erythromycin resulted in clinical improvement. Appropriate cultures were negative and tuberculin skin testing was unremarkable. However, chest radiographic findings persisted and he was re-admitted to the hospital complaining of increasing dyspnea and copious yellow sputum production.

He was a cachectic black male in moderate respiratory distress. His temperature was 37.1°C, blood pressure 120/70 mm Hg, pulse rate 144/min, and respiratory rate 24/min. Several soft, movable posterior cervical lymph nodes were noted bilaterally. Signs of left lower lobe consolidation were present. Heart exam was normal except for an accentuated P2 component of the second heart sound. Examination of the abdomen and genitalia was unremarkable. Digital clubbing and peripheral edema were absent.

Room air arterial blood gases were as follows: PaO₂ = 54mm Hg, PaCO₂ = 31mm Hg, pH = 7.46. A serum WBC count was 10,000/mm³ with 80% neutrophils. The admission chest radiograph (see Figure 1) revealed almost total opacification of the left hemithorax and a small pleural effusion on the right.

From the departments of medicine and pathology, University Medical Center, Jackson, MS.

Presented in part at the Louisiana-Mississippi Regional Meeting of the American College of Physicians, March 4, 1983.



Figure 1. Admission chest radiograph demonstrating opacification of left lung and small right pleural effusion.

Thoracentesis on the right side yielded 30 ccs of yellow, turbid fluid. The fluid was an exudate, containing $6000/\text{mm}^3$ WBC, all lymphocytes. The pleural fluid pH was 7.29. Amylase and glucose determinations were normal. Bacterial and fungal examinations of the fluid were unremarkable, but cytologic studies demonstrated malignant cells typical of adenocarcinoma with some broncho-alveolar cell characteristics (see Figure 2).

Fiberoptic bronchoscopy revealed generalized erythema and edema of the bronchial mucosa, but no endobronchial lesions were seen. Bronchial washings contained malignant cells similar to those found in the pleural fluid.

The patient became more dyspneic and hypoxicemic, the right lung opacified, and he died 10 days after admission. No autopsy was performed.

Discussion

Pulmonary malignancy is becoming a more commonly recognized feature of progressive systemic sclerosis. Talbott and Barrocas, in 1980, reviewed data from 54 reported cases of carcinoma of the lung in patients with PSS.³ Predisposing factors included

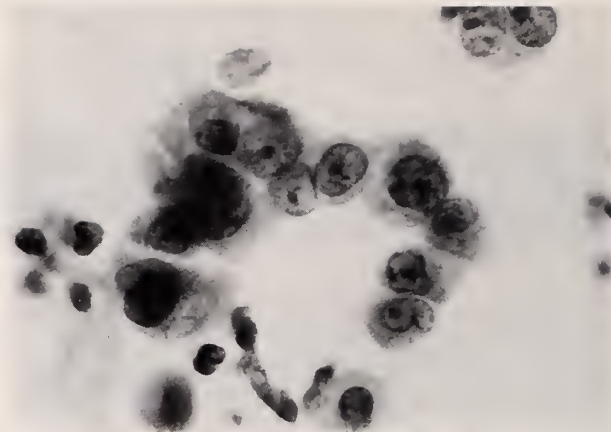


Figure 2. Cluster of cells in pleural fluid characteristic of adenocarcinoma (Papanicolaou Stain, x 100).

underlying pulmonary fibrosis and long duration of PSS symptoms. Since the incidence of pulmonary fibrosis in PSS may be as high as 95%⁴ it is surprising more pulmonary malignancies have not been documented.

The pulmonary fibrosis of PSS is histologically similar to that of idiopathic pulmonary fibrosis. Both are characterized by collagen deposition in basement membranes which results in fibrinoid changes in small pulmonary blood vessels. Infiltration by inflammatory cells ensues, resulting in obliteration of alveoli and formation of cystic spaces appearing radiographically as "honeycombing."³

Patients with pulmonary fibrosis appear prone to develop pulmonary malignancies. In 1939 Friedrich suggested that malignant changes in pulmonary fibrosis were analogous to the development of hepatomas in patients with hepatic fibrosis.⁵ Fraire and Greenberg found varying degrees of squamous, cuboidal and columnar metaplasia in 16 patients with diffuse interstitial fibrosis, three of whom had carcinoma.⁶ It has been proposed that terminal bronchiolar epithelium and epithelialized cystic spaces have proliferative potentialities from which malignant cells arise.³

A tissue diagnosis of primary pulmonary malignancy was not possible in our case, due to lack of autopsy material. There was no clinical evidence of malignancy elsewhere. Metastatic testicular cell carcinoma and pulmonary mesothelioma were considered as alternative diagnosis, but felt to be unlikely. The age of our patient and his initial response to antibiotic therapy were two factors causing delay in diagnosis. Lopes, et al, reported finding alveolar cell carcinoma postmortem in a 24-year-old male with pulmonary fibrosis and symptoms of PSS.

To our knowledge, our patient is the youngest

reported case of pulmonary malignancy occurring in PSS. His long history of PSS and underlying pulmonary fibrosis were probably factors leading to this complication. We would suggest consideration of malignancy in all patients with PSS who have abnormal chest radiographs, regardless of age.

Summary

Pulmonary malignancy is an uncommon but recognized complication in patients with progressive systemic sclerosis (PSS). We describe a 21-year-old male who developed pulmonary carcinoma after a 14-year history of PSS. Increased awareness of this lethal association is warranted even in younger patients with PSS. ★★★

2500 North State Street (39216)

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Radiologic Seminar CCXXVIX: Non-Oat Cell Carcinoma of the Lung Controlled by Irradiation and Adjunctive Medication — A Case Report

R. ARNOLD SMITH, M.D.

Jackson, Mississippi

LUNG CANCER IS INCREASING in incidence far more rapidly than any other type of cancer. The cure rate for lung cancer has changed very little in the last fifteen years. If lung cancer could be excluded from statistics which describe success with cancer management over the last decade, then physicians would appear to be doing moderately well. Because of the rapid increase in lung cancer incidence and because of its refractory nature to treatment, the overall death rate from cancer has not improved significantly even though many types of cancer have become far more curable. Non-oat cell lung cancer is responsible for approximately 20% of all cancer deaths.¹ In spite of large patient populations available for study, the results of cytotoxic chemotherapy have been discouraging.²⁻⁵

It was in April 1977 when this author reported the almost total local regression of a massive adenocarcinoma in the right upper lung with high dose local radiotherapy associated with anticoagulation, estrogen, and multivitamin. The present report describes what I believe is the only report of extensive non-oat cell lung cancer which has survived to approximately five years.

The patient was a 47-year-old black male and long term heavy smoker who presented to this department on May 2, 1978 with a recent work-up for non-oat cell lung cancer. He had presented with a duodenal ulcer, and his chest x-ray (see Figure 1) had demonstrated (1) left pleural effusion, (2) enlarged heart shadow compatible with pericardial effusion, (3) nodular protrusion from the right mediastinum, in-

Non-oat cell lung cancer when extensive, ie, associated with malignant pleural or pericardial effusion, is incurable with current accepted treatment modalities. The author reports a case of apparent cure believed to be the first such report in the literature.



Figure 1. Chest x-ray at presentation showing pleural effusion, enlarged cardiac shadow due to pericardial effusion and protrusion of mediastinal tumor in contralateral suprahilar region.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiation Therapy, Mississippi Baptist
Medical Center, Jackson, MS

dicating soft tissue mass. At thoracotomy for cardiac tamponade he was found to have fluid in the left chest cavity as well as in the pericardial space. Samples from both fluids were returned as showing malignant cells compatible with poorly differentiated squamous cell carcinoma. The pericardium was biopsied as a window was established, and nodes were removed from the mediastinum. Both these specimens showed the same tumor. The patient was referred for radiotherapy and began split course radiotherapy with an initial 3000 rads in two weeks. Concurrent with this first treatment he received estrogen/androgen mixture (Premarin with MTTM), multivitamin, and Vitamin E, 400 international units three times a day. The patient returned for additional radiotherapy and received a final six treatments with a total dose of 5130 rads. After the end of treatment additional drugs were added which included Vitamin C, 10 grams daily as the sodium salt; cyclophosphamide (CytosanTM), 25 mg twice a day; selenium, 100 micrograms daily; and Iodo-Niacin, two tablets twice daily. These medicines were not started all at once, but were started gradually over a period of the next two years. On December 22, 1978 the patient's wife stated that she had never seen him looking so good. The patient gained weight and muscular strength on his treatment. Figure 2 shows the portal



Figure 2. Port film employed.

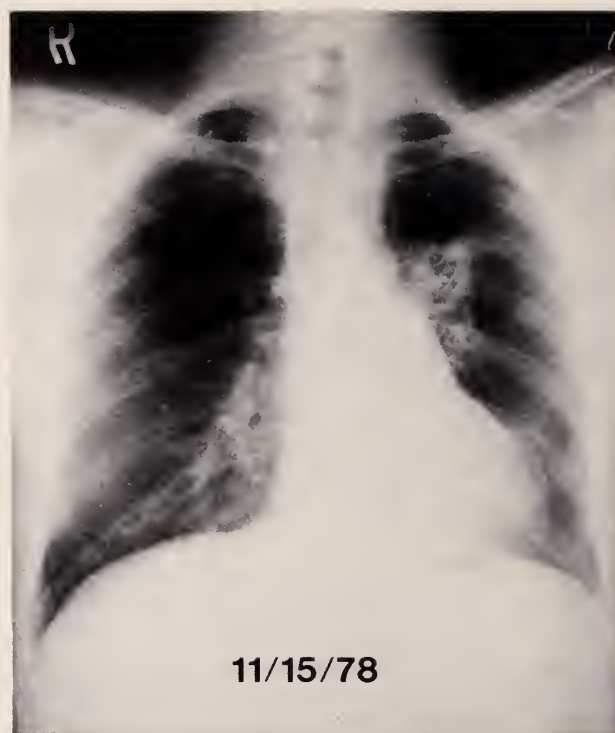


Figure 3. Early fibrosis in irradiated field a few months after treatment.

employed for treatment, Figure 3 shows the early radiation fibrosis in the treated volume, and Figure 4 shows his most recent chest x-ray. The patient is currently director of the Black Arts Music Society of Mississippi and is an active promoter of jazz musicians in the state of Mississippi. He recently gave a benefit for the American Cancer Society. He is active and in a state of clinical good health.

Verification of Data

The author had never seen this type of response before and it seemed prudent to make a thorough evaluation of the histology. The slides were reviewed at this institution by Dr. Roger Arhelger of the pathology department, and Dr. Arhelger interpreted the histology as representing poorly differentiated adenocarcinoma. To obtain the report of a final referee pathologist, the patient's slides were sent to Dr. Raymond Yesner, who has been the pathologist to classify the Veterans' Administration Lung Cancer Study Group (VALCSG) histology. Dr. Yesner described the tumor as a papillary adenocarcinoma. The consensus opinion was bronchogenic carcinoma.



Figure 4. Chronic retracted radiation fibrosis but no evident tumor.

Discussion

In the annals of the Royal College of Surgeons⁶ there was a paper published in 1972 by Dr. Christopher John Magarey which was the substance of the Hunterian lecture delivered on July 15, 1971. Dr. Magarey quotes Bernard Shaw in the introduction, "There is at bottom only one genuinely scientific treatment of all diseases and that is to stimulate the phagocytes . . . they devour the disease; and the patient recovers — unless of course he's too far gone." Dr. Magarey further states that John Hunter observed the progress of many cancers, but except for the local excision of superficial tumors there was little he could do to prevent their growth and spread.

Dr. Magarey further states that "many surgeons have come to doubt the value of the purely anatomical approach. They suggest that the normal tissues may prevent or retard the growth of tumor cells, so these tissues should be damaged as little as possible. If we could understand these natural defenses we might be able to preserve them during the treatment of cancer and even increase their effectiveness, and so further improve the results." The paper proceeds to describe a series of experiments which studied the activity of the reticuloendothelial system in its ability to handle radio-isotope labeled aggregates of



Figure 5. Papillary colonies of adenocarcinomatous appearing cells infiltrating pericardium.

albumin. The author reported the development of a technique for quantifying this physiologic function and he studies phagocytic function in a number of circumstances. In patients with carcinoma of the bronchus, failure of clinical response to radiotherapy was associated with a depressed phagocytic function. Symptomatic palliation was associated with an improved phagocytic function. Cytotoxic chemotherapy in high doses with either 5FU or Cytosan seem to markedly depress phagocytic function. Estrogen (diethylstilbesterol) on the other hand, produced a very significant improvement in phagocytic function when given during radiotherapy to bronchogenic carcinoma.

In the completion of his paper Dr. Magarey states "estrogens have received little attention as non-specific reticuloendothelial stimulants in the treatment of cancer, but there is evidence that they may be effective." Dr. Magarey further suggests their adjuvant use during radiotherapy may be important.

In view of Magarey's findings, it should not be surprising that women receiving replacement estrogens after the menopause had an age specific mortality rate only one-third (.37) that of women not receiving such treatment.⁷

It was another surgeon, Dr. Ewan Cameron, who in collaboration with Dr. Linus Pauling claimed a marked improvement of advanced cancer patients when they were given high dose Vitamin C in the amount of 10 grams daily. The Vitamin C was given as an aqueous solution of the sodium salt. Dr. Cameron formerly was the surgical registrar of a large Scottish hospital, and he now is the Medical Director of the Linus Pauling Institute. Drs. Cameron and Pauling describe a significant incidence of patients with cancer who enter into some kind of a remission of a sustained nature.⁸ In a discussion with Dr. Cameron on February 11, 1983, Dr. Cameron stated that of 222 primarily or secondarily unresectable colon cancers some 17 are now five year survivors. Dr. Cameron stated that their luck with non-oat cell lung cancer had been less successful, and they had no survivors out over three years with extensive disease.

The possibility for cure of extensive non-oat lung cancer with cytotoxic chemotherapy appears nil. Lanzotti, et al published a year of M. D. Anderson Hospital experience,⁴ and of 187 extensive patients (149 non-oat cell) there were no survivors past 90 weeks. A paper in this year's *Cancer*² describes the natural history of non-oat cell lung cancer with pericardial effusion from the Galveston branch of the University of Texas Medical System. In this report of some 65 patients, all were dead by 118 weeks. The author has discussed Mr. Reese with Dr. James Cox, who is familiar with the VA patients; Dr. Manual val Divieso, who is familiar with the M. D. Anderson Hospital non-oat cell lung survival; and Mr. John Horn, statistician with the National Institute of Health, who confirm that all patients with malignant pleural effusion and large cell undifferentiated carcinoma or adenocarcinoma of the lung were dead before the end of four years.

This patient along with two other unusual patients, one of these other two patients also having pleural space disease and who will also be at five years quite soon, are believed to be unique in the literature. Both of the other patients were treated with a combination immunosupportive regimen including estrogen, high dose Vitamin C, high dose Vitamin E, selenium, and iodine. (The details of treatment are to be published in far greater detail elsewhere. The manuscript will be available upon request.) The selenium⁹ and Vitamin E¹⁰ have been

the subject of multiple studies in recent years which describe their potent stimulatory effect on immune function. Iodine^{11, 12} is essential for some types of host offensives against cancer. Cyclophosphamide (CytosanTM) in low doses is an immune stimulant.^{13, 14}

Non-oat cell lung cancer with malignant spread to the pleural space is tantamount to a death sentence. It is a trap from which there has been no known escape. The author believes that Dr. Magarey, Dr. Cameron, and Dr. Pauling are correct. The clinical use of estrogen and Vitamin C can be used to influence the outcome of this dread disease. The protracted growth arrest potential of Vitamin C previously documented by Cameron and Pauling may extend to the non-oat cell lung cancers if other agents, such as estrogen, Vitamin E, or selenium or iodine, are used in conjunction. The time honored recipe for control in the pediatric tumors, surgical removal or radiotherapy for local disease combined with effective systemic therapy, may have comparable application in the non-oat cell lung cancer patients. The combination drug therapy promising success, however, appears more and more likely to be that which stimulates immunity rather than that which attempts to influence tumor cell growth by direct cytotoxic effects. ★★★

1225 North State Street (39201)

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Journal MSMA policy limits references published to 10. For a complete bibliography, please write to the author.

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The President Speaking

Our Common Focal Point

Whitman B. Johnson, Jr., M.D.
Clarksdale, Mississippi

I would like to start this year by thanking Sidney and congratulating him on a job well done during turbulent times. His will be a hard act to follow.

Now that the annual session, with its natural turf battles and divisiveness, is over, and the "central" and "peripheral" scotomata have been resolved for the present, let us focus on and face our upcoming problems with unity.

Since the end of World War II, when essentially every physician in the state had a common interest in family type practice, we have split into more subdivisions than the Christian religion. In minor areas, that which is sugar and honey for one group is lemon juice for another. Nobody likes to swallow anything that sour!

Now is the time, with the issues and transitions we are to face in the next few years, to "cool" things off and stand together for the good of all medicine. After all, lemon juice, ice, sugar, and water make a pretty good drink.

No matter how many groups into which we divide, there is still one common focal point — the patient. Anything we can do in his or her behalf benefits us all. ★★★

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION
VOLUME XXIV, Number 6
JUNE 1983

MAOS

A new craze has swept in on us, inundating those of us out here laboring in the vineyard. I call it the medical abbreviation obfuscation syndrome (MAOS). Each and every paper you try to read nowadays is littered with groups of capital letters, newly coined, important-looking, and most never to be seen again. It's like the "New Deal" all over again. Remember? NRA, WPA, CCC, ETC., ETC. It's really tough on us scanners, kind of like a tennis match.

Truly, MAOS (see above) is a spreading malaise. Each weekend doctor has his own set of hieroglyphics, with which my charts are sprinkled every Monday morning. And have you tried to interpret a newborn form? The neonatologists are past masters of this art — MAOS at its finest! The nurses are getting in on the act, too. On perusing her notes on one of my more cantankerous old patients, I inquired of this new nurse as to how she had found out on one shift what I had been aware of for 20 years. She had charted in beautiful script, "Pt., SOB."

Here are a few pearls gleaned from last week's *JAMA*. (Now they've got me doing it!) ALS, GFR, CDC, NIOSH, HAS, AONA, ERF, AMACO, FTC, WMA, IPV, OPV, PTT, CNS, BCH, AMLI, PEFR, NIH, ESRD, GNP, MAP, CAH, CPH, HBV, CT, OR, DOC, BP & APM.

Admittedly some are as familiar as a bump on your nose, but some are as esoteric as an orf lesion on someone who didn't tell you he was a shepherd!

The PSRO (Oh, No!) has tried to teach us to write our progress notes for others to read and be informed, not for our own edification. I feel a little of this philosophy applies to the usage of abbreviations. Perhaps the MAOS is a transient entity. I surely hope so!

ARTHUR A. DERRICK, JR., M.D.
Associate Editor

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PERSONALS

JAMES ACHORD of Jackson has been named president-elect of the American College of Gastroenterology.

G. WILLIAM BATES of Jackson has been named an Alfred P. Sloan Fellow by the Massachusetts Institute of Technology.

KENDALL T. BLAKE of Jackson was recently inducted as a fellow of the American Academy of Orthopedic Surgeons.

ROBERT E. BLOUNT of Jackson recently was awarded designation as an American College of Physicians Master in recognition of his contributions to medicine.

GREGORY F. BREDEMEIER announces the opening of his office for the practice of general medicine at 200-A Oak Lane in Gulfport.

WALLACE CONERLY of UMC was a site visitor for the Joint Review Committee for Respiratory Therapy Education at the Gulf Coast Community College in Panama City, Florida.

CARL EVERS of UMC presented a paper and attended the executive committee meeting of a regional Association of American Medical Colleges meeting in St. Simon's Island, Georgia.

WILLIAM C. HOPPER, JR. of Gulfport presented a paper on children's orthopaedics at the Nemours Children's Hospital in Jacksonville, Florida, recently.

MICHAEL E. JABALEY of Jackson attended the semi-annual meeting of the American Board of Plastic Surgeons in Boston and presented a paper at the annual meeting of the American Association of Plastic Surgeons, also in Boston. At the annual meeting of the American Society for Surgery of the Hand, in Anaheim, California, he taught a course and received the Bunnell Fellowship Award.

ERIC LINDSTROM of Laurel was recently appointed by the Jones County Board of Supervisors to the board of trustees of Jones County Community Hospital.

RICHARD E. LOPEZ announces the opening of his office for the general practice of medicine at 02300 Pass Road in Gulfport.

JAMES MARTIN, JR. of UMC spoke at the University of North Carolina alumni meeting in Chapel Hill.

CONNIE McCAA of UMC chaired the recent meeting in Bethesda, Maryland, of the hypertension subcommittee of the National Institute of Health advisory committee on arteriosclerosis, hypertension and lipid metabolism.

WILLIAM M. MCKELL, JR. of Jackson has been appointed to the membership committee of the American Society of Gastrointestinal Endoscopy.

WILLIAM NICHOLAS of UMC was guest speaker and chaired a session at the recent annual meeting of the Mississippi Dietetic Association in Biloxi.

GUY T. VISE, JR. of Jackson recently was installed as chairman of the Council of the Southern Medical Association.

ELBERT A. WHITE, III, of Corinth recently was named a fellow of the American College of Surgeons.

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NEW MEMBERS

CHILDREY, GREGORY W., Columbus. Born Feb. 26, 1952, Atlanta, GA; M.D., Medical College of Georgia, Augusta, June 1978; interned University of South Alabama Medical Center, Mobile, one year; ob-gyn residency, same, 1979-82; elected by Prairie Medical Society.

CRENSHAW, CHARLES N., III, Newton. Born Chunky, MS, April 30, 1953, M.D., University of Mississippi School of Medicine, Jackson, 1980; interned St. Francis Hospital, Memphis, TN, one year; elected by East Mississippi Medical Society.

FOREMAN, SUSAN D., Jackson. Born Wilmington, NC, June 1, 1952; M.D., University of North Carolina School of Medicine, Chapel Hill, 1978; interned and pediatric residency, University Medical Center, Jackson, MS, 1978-81; pediatric neurology fellowship, same, 1981-82; elected by Central Medical Society.

KNIGHT, CHARLES S., Jackson. Born Mt. Olive, MS, July 7, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned and pediatric residency, University Medical Center, Jackson, MS, 1971-73 and 1975-76; pediatric neonatology fellowship, same, 1976-78; elected by Central Medical Society.

LANCASTER, MARGIE GLENN, Whitfield. Born Rich-ton, MS, Feb. 2, 1926; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned and neurology residency, University Medical Center, Jackson, 1969-73; elected by Central Medical Society.

MANIKTAHLA, K. N., Batesville. Born India, April 3, 1941; M.D., Government Medical College Patiala, India, 1964; interned Rajendra Hospital, Patiala, India, May-Dec. 1963; interned Mayo Clinic, Rochester, MI, July-Dec. 1980; urology residency, Metropolitan Hospital, Cleveland, OH, 1971-74 and Akron Children's Hospital, Akron, Ohio; elected by North Mississippi Medical Society.

PETERS, JAMES G., Louisville. Born Macon, MS, June 7, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and family practice residency, University of Alabama College of Community Health Sciences, Tuscaloosa, 1978-82; elected by East Mississippi Medical Society.

STEELE, ALBERT WAYNE, Jackson. Born Greenwood, MS, Feb. 16, 1953; M.D., University of Mississippi College of Medicine, Jackson, 1979; interned Baptist Hospital, Memphis, TN, one year; anesthesiology residency, Galveston, TX, July-Dec. 1980; internal medicine residency, Baptist Hospital, Memphis, TN, Feb.-Nov. 1982; elected by Central Medical Society.

WELCH, WILLIAM C., JR., Jackson. Born Tupelo, MS, Oct. 30, 1935; M.D., University of Mississippi College of Medicine, Jackson, 1961; interned and psychiatry residency, University Medical Center, Jackson, 1961-62 and 1976-79; elected by Central Medical Society.

WETZEL, WILLIAM J., Jackson. Born New York, NY, Jan. 28, 1949; M.D., Albany Medical College of Union University, Albany, NY, 1973; interned and pathology residency, University of Florida, Gainesville, 1973-78; elected by Central Medical Society.

The Mississippi State Medical Association is grateful to the following companies for their financial support of the 115th Annual Session:

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Dr. Johnson Is Inaugurated, Dr. Moffitt Named President-Elect

Dr. Whitman B. Johnson of Clarksdale was inaugurated 1983-84 president at the closing meeting of the 115th Annual Session held last month in Biloxi. He succeeds Dr. Sidney O. Graves of Natchez. Dr. Ellis M. Moffitt of Jackson was named president-elect.

More than 900 registered for the five-day session, which featured a full program of scientific, business and fellowship activities.

Special guest speaker at the opening session of the House of Delegates on Thursday was Dr. William Y. Rial, president of the American Medical Association.

The scientific program listed more than 30 speakers from across the country who made presentations

during meetings of the 14 scientific sections and a number of medical specialty organizations.

Highlighting the scientific program was the presentation of the third annual James Grant Thompson Memorial Lecture, which was delivered by Dr. John Beal of Chicago, president of the American College of Surgeons.

The House of Delegates handled a heavy business agenda which included elections to fill vacancies in MSMA offices, action on more than 25 reports and resolutions, and presentation of awards. Delegates approved a major reorganization plan for the association, among other actions.

A summary of House of Delegates actions appears on pages 165 and 166 of this issue.



Dr. Whitman B. Johnson of Clarksdale, center, was inaugurated president of the association during the 115th Annual Session. With him are Dr. Ellis M. Moffitt of Jackson, at left, 1983-84 president-elect, and Dr. Sidney O. Graves of Natchez, immediate past president.



Dr. Ellis M. Moffitt, left, administers the oath of office to Dr. Whitman B. Johnson, right, assisted by Charles Mathews, MSMA executive director.



Dr. Graves receives the James Grant Thompson Memorial Past President's Pin from Mrs. Thompson.



Prior to addressing the House of Delegates Dr. William Y. Rial, right, president of the American Medical Association, presented Dr. J. O. Manning with three AMPAC awards. The MMPAC won two first place awards (for number of sustaining members and for average contributions per member) and a third place award (all events category).



Dr. Norman A. Nelson, right, dean of the University of Mississippi School of Medicine, accepts a check for \$19,292.04. The check represents AMA-ERF contributions to the school from Mississippi physicians, alumni, and their spouses. On hand for the presentation was Mrs. Gary Groff of Ocean Springs, MSMA Auxiliary AMA-ERF chairman.

Elections Highlight House of Delegates Sessions

In addition to electing Dr. Ellis M. Moffitt to the post of president-elect, delegates to the 115th Annual Session cast ballots to elect other MSMA officers.

Dr. C. G. Sutherland of Jackson was elected to the Board of Trustees, and Drs. W. Bernard Hunt of Grenada and George L. Arrington of Meridian were re-elected to the Board.

Elections to fill two of three AMA delegate posts were held, and Drs. Ed Hill of Hollandale and Sidney Graves of Natchez were named to the positions. Drs. Stanley A. Hill of Corinth and Carl Evers of Jackson were elected as alternate delegates.

New vice-presidents of the MSMA are Drs. Lee H. Rogers of Tupelo, Stanley A. Wade of Meridian, and Mal G. Morgan of Natchez. Dr. Myron W. Lockey of Jackson was elected editor of JOURNAL MSMA. Dr. Joseph E. Johnston of Mt. Olive was named to a three-year term as associate editor.

Other posts determined by the elections include: Council on Budget and Finance — Dr. W. Joseph Burnett of Oxford; Council on Constitution and Bylaws — Dr. Max L. Pharr; Judicial Council — Drs. L. Stacy Davidson of Cleveland, William A. Spencer of Sardis, and Earl E. Whitwell of Tupelo; Council on Medical Education — Drs. L. D. Henson of Kilmichael, Doyle P. Smith, Jackson, and Joe S. Covington of Meridian; Council on Legislation — Drs. Edwin M. Hemness of Clarksdale, Thomas S. Glasgow of Oxford, and Lee H. Rogers of Tupelo; and Council on Medical Service — Drs. Stanley Hartness of Kosciusko, C. David Scruggs of Jackson, and Oliver W. Byrd of Quitman.

Board of Trustees Elects New Officers

Dr. J. O. Manning of Jackson was elected chairman of the MSMA Board of Trustees during the board's meeting May 15 in Biloxi. Dr. W. Joseph Burnett of Oxford was named vice-chairman and Dr. Roy D. Duncan of Pascagoula was named secretary.

Other members of the board are: Drs. Virginia S. Tolbert, Ruleville; William C. Gates, Columbus; William B. Hunt, Grenada; C. G. Sutherland, Jackson; George L. Arrington, Meridian; W. Boyce White, Laurel; and David R. Steckler, Natchez.

A reorganization plan approved by the House of Delegates will produce several changes in the association's districts and will reduce the number of



Dr. Thomas F. McDonnell of Hazlehurst, left, was named recipient of the 1983 MSMA-Robins Award for Community Service. Mr. Phil Taylor of Hattiesburg presented the award to Dr. McDonnell.



Dr. R. Faser Triplett of Jackson, left, paused after the House of Delegates session to congratulate Dr. C. G. Sutherland on his election to the Board of Trustees.

trustees. The plan will remain on the table for one year prior to final adoption at the 116th Annual Meeting.



Members of the House of Delegates prepare to mark ballots.



115th Annual Session, May 11-15, 1983

HOUSE OF DELEGATES HANDLES BUSY AGENDA

The House of Delegates of the Mississippi State Medical Association handled a busy agenda of reports and resolutions at the 115th Annual Session of the association in Biloxi. The official transactions of the meeting will be mailed to all delegates.

The MSMA House of Delegates took these major actions:

- Canceled the second phase of a two-year dues increase in light of the association's improved financial status.
- Recommended that there be physician representation on hospital governing boards, preferably as voting members.
- Approved organization of a 501(c)(9) trust to provide insurance benefits to members of the association, their families and employees.
- Called for reasonable and nominal co-payments to be placed on all Medicaid services.
- Named Dr. Moncure Dabney of Crystal Springs Editor Emeritus of the JOURNAL MSMA in recognition of his long and distinguished service.
- Urged a study of the need for minimal criteria for so-called emergency care clinics.
- Urged the State Department of Health to establish a division to monitor the problems of exposure to chemicals in food, air and water.
- Expressed continued concern over expanded fee for service activities of the State Department of Health with respect to their possible duplication of local private health services.
- Urged that the health hazards of smoking marijuana be widely publicized to young Mississippians.
- Urged the State Board of Medical Licensure to re-assess reciprocity agreements with other states in light of recent policies to license individuals who have graduated from medical schools which are not documented to have met the standards required by the Liaison Committee on Medical Education.
- Urged distribution of a uniform claim form for disability insurance similar to that for health insurance.
- Banned smoking at all official meetings of the association.
- Funded a country doctor's office to be erected at the new Agricultural and Forestry Museum in Jackson.
- Established a Section on Emergency Medicine as one of the scientific sections of the association.
- Increased the term of office of vice-presidents of the association to three years.
- Presented the 1983 MSMA-Robins Award for Community Service to Dr. T. F. McDonnell of Hazlehurst.
- Presented \$19,292.04 to the University of Mississippi School of Medicine representing 1982 AMA-ERF contributions to the school from Mississippi physicians and spouses.
- Adopted several recommendations to reorganize the organizational structure of the association which will be on the table for final adoption at the 1984 Annual Session. Included in the recommendations are:

(a) Change the ratio of delegates elected to the MSMA House of Delegates by the component societies from one delegate per 50 members to one delegate per 10 members.

(b) Combine current association districts 2 and 4.

(c) Transfer West Mississippi Medical Society from current association district 5 to new association district 6.

(d) Delete certain committees required by the MSMA bylaws, recognizing that the committees can be appointed on an *ad hoc* basis as needed.

(e) Replace the current annual scientific section format with plenary sessions in surgery and medicine.

(f) Encourage and give staff support to state specialty societies conducting meetings concurrently with the MSMA Annual Session.

Serving on reference committees of the House were:

Reference Committee on Rules and Order of Business

Stanley A. Hill, M.D., Chairman
Richard F. Riley, M.D.
Edward Pennington, M.D.

*Reference Committee on Reports of Officers,
Board of Trustees and Councils*

Mal G. Morgan, M.D., Chairman
J. M. Patterson, M.D.
Robert L. Buckley, Jr., M.D.
L. Stacy Davidson, Jr., M.D.
Joseph E. Johnston, M.D.

Reference Committee on Constitution and Bylaws

George D. Purvis, Jr., M.D., Chairman
Frederick E. Tatum, M.D.
Everett H. Crawford, M.D.

Credentials Committee

J. Elmer Nix, M.D., Chairman
Karl W. Hatten, M.D.
Horton G. Taylor, M.D.

Nominating Committee

Charles R. Jenkins, M.D., Chairman
Virginia S. Tolbert, M.D.
Horton G. Taylor, M.D.
William B. Howard, M.D.
A. A. Derrick, Jr., M.D.
Myron W. Lockey, M.D.
Richard M. Vise, M.D.
Mal G. Morgan, M.D.
Roy D. Duncan, M.D.

**116th Annual Session
May 16-20, 1984 (Wednesday-Sunday)
Royal d'Iberville Hotel, Biloxi**



Guests attending the annual President's Reception were greeted by Dr. and Mrs. Graves, and by MSMA Board of Trustees chairman Dr. Ellis Moffitt, left. The reception, sponsored this year by Canton Exchange Bank, marked the beginning of the five-day Annual Session.

President's Reception



Mrs. Whitman B. Johnson, left, and Dr. Nina B. Moffitt greeted MSMA and MSMA Auxiliary members and guests attending the President's Reception.



Dr. Whitman B. Johnson, left, talked with two other Clarksdale physicians, Dr. George Furr, center, and Dr. Edwin Hemness.



Among those enjoying the reception were Dr. and Mrs. Gerald Gable, left, and Dr. and Mrs. Fred Tatum, all of Hattiesburg.



Dr. Graves, center, posed with representatives of the Great Southern National Bank, sponsors of the reception preceding the annual membership banquet. With Dr. and Mrs. Graves are, from left, Bill Hankins, chairman of the executive committee, Jim Speed, chairman of the Board of Directors, and Jim Mitchell, chief operating officer.



Entertainer Mark Russell, right, spoke with Bob Boteler, senior vice president of Great Southern National Bank, and Mrs. Boteler.



Among those welcoming Mark Russell to Mississippi's Gulf Coast were Dr. Faser Triplett, left, and Dr. Whitman B. Johnson.



Candidates attending the MMPAC reception included, at left, Dennis Dollar, shown here talking with Dr. Lester Webb of Calhoun City, and Brad Dye, greeting Dr. and Mrs. W. A. Middleton of Winona.



A number of candidates for statewide political offices attended the MMPAC reception. Among those greeting Mississippi physicians and their spouses was Evelyn Gandy, shown here as she spoke with Dr. Ellis Moffitt.



Members of the Past President's Club were photographed as they gathered for their annual breakfast. Seated, from left to right, are: Dr. James T. Thompson, Moss Point; Dr. Guy T. Vise, Sr., Meridian; Dr. Everett Crawford, Tylertown; Dr. J. T. Davis, Corinth; Dr. Omar Simmons, Newton; and Dr. Lawrence Long, Jackson. Standing, left to right, are: Dr. Joe Rogers, Gulfport; Dr. C. P. Crenshaw, Collins; Dr. James O. Gilmore, Oxford; Dr. Sidney O. Graves, Natchez; Dr. Carl Evers, Jackson; Dr. Arthur Derrick, Durant; Dr. Stanley Hill, Corinth; Dr. Gerald Gable, Hattiesburg; Dr. Charles R. Jenkins, Laurel; Dr. Lyne Gamble, Greenville; and Dr. Faser Triplett, Jackson.



Dr. Ellis Moffitt, chairman of MSMA's Board of Trustees, hosted a luncheon honoring members of the Fifty Year Club. Pictured above, from left, are Dr. J. T. Davis of Corinth, Dr. Omar Simmons of Newton, Dr. T. J. Barkley of Belzoni, Dr. Guy T. Vise of Meridian, and Dr. Thomas Clay of Tutwiler, who was accompanied to the luncheon by his son, T. F. Clay, Jr. Other Fifty Year Club members who attended but are not pictured, are Dr. Samuel B. Caruthers of Grenada, Dr. G. T. Sheffield of Gulfport, Dr. Stanley Hill of Corinth, and Dr. Lawrence Long of Jackson.



The winning jackfish was caught by Mrs. Frank E. Dement of Hattiesburg, left. Mrs. Unita Taylor of Calhoun City, mother of Dr. Horton Taylor, displays her trophy for the winning Spanish mackerel. Both fish were caught aboard the "Blue Runner" on the second day of the fishing rodeo.



Dr. James Funderburg of Natchez won the trophy for largest Spanish mackerel on the first day of the fishing rodeo.



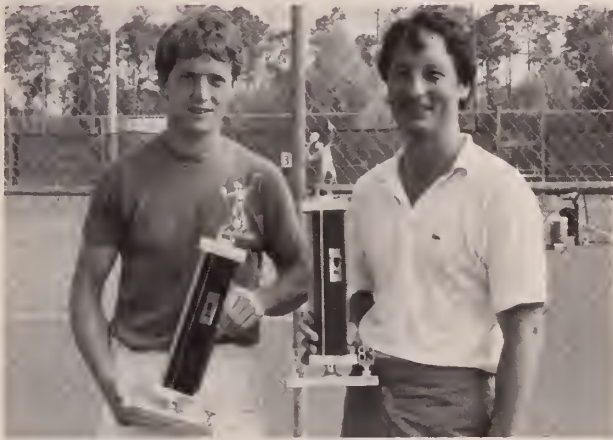
Mark Haygood of Washington, DC, a member of the AMPAC staff, displays his trophy-winning jackfish.



Elaine Hudson, daughter of Dr. and Mrs. Harold Hudson of Tupelo, was a participant in the fishing rodeo.



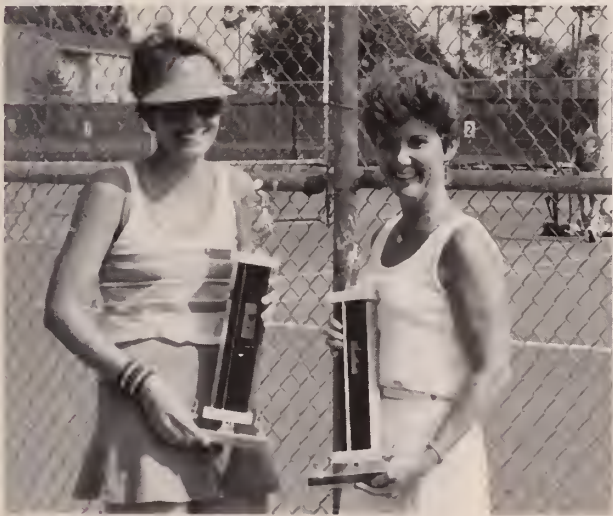
Dr. Howell Crawford, Dr. J. Dan Mitchell, and Mrs. James Grant Thompson, who were aboard the "Miss Hospitality," show off part of the day's catch.



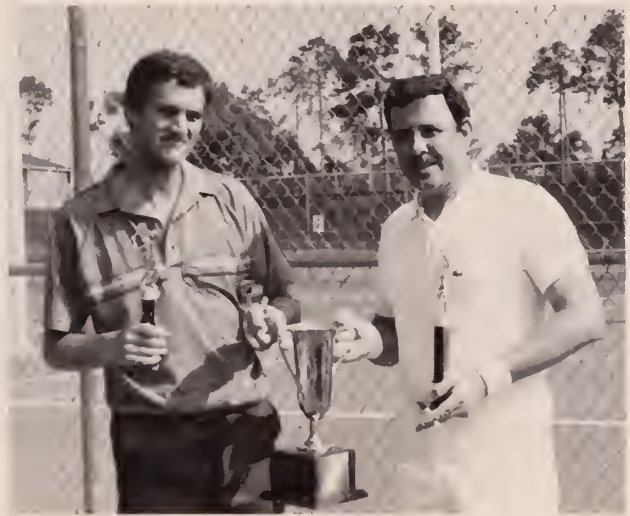
Dr. Winn Walcott, left, and Dr. Ben Yarbrough received the winning trophy in the men's doubles competition.



Dr. Bob Smith, left, and Dr. Francis Morrison won the second-place trophy in the tennis tournament.



Dr. Carol Ann Smith, left, and Dr. Betty Bailey received the first-place trophy. Second-place went to Nannette Weems and Ruth White.



Dr. Bob Howland, left, and Dr. Bill Gates were consolation winners in men's doubles competition.



Past presidents of the MSMA Auxiliary gathered for their annual breakfast.



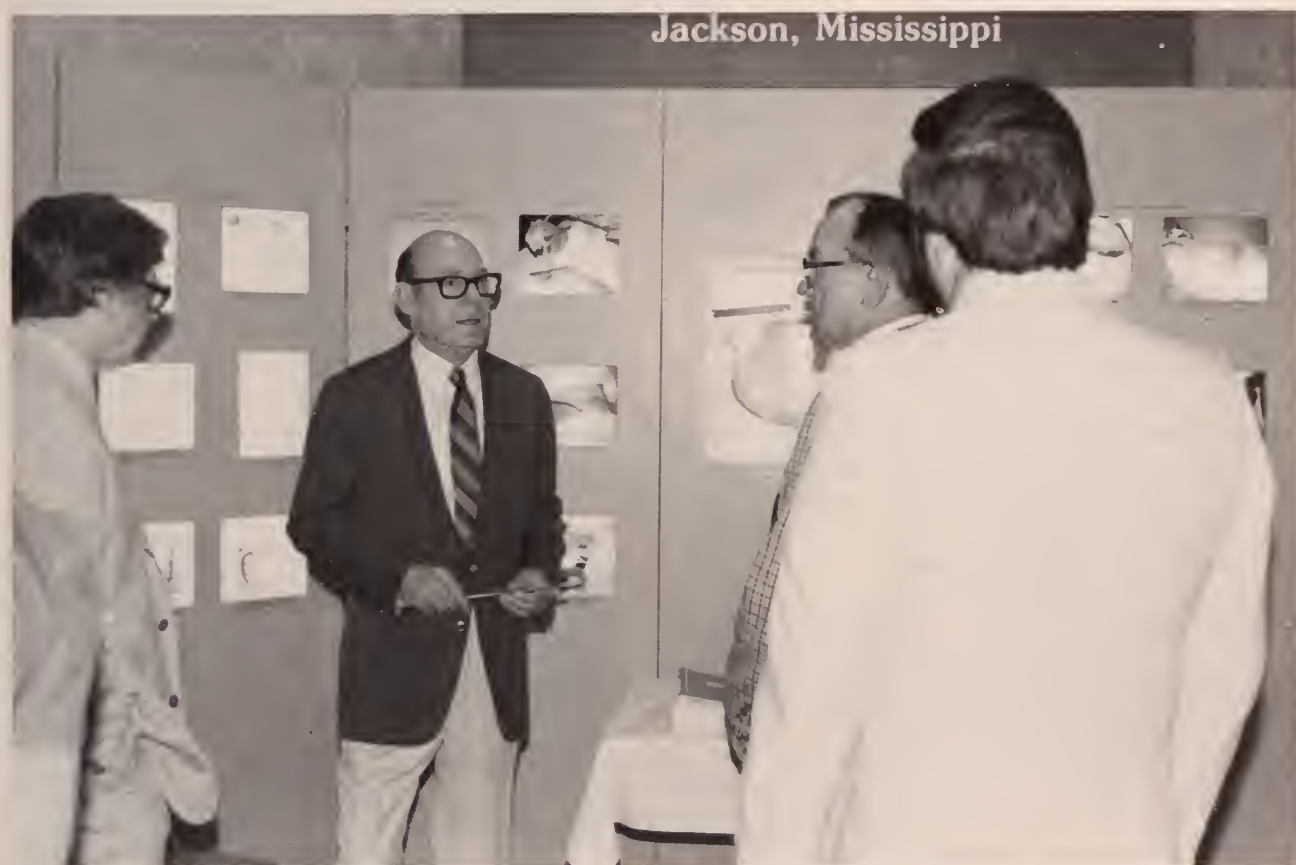
Mrs. Stanley Hartness, seated left, was installed as 1983-84 president of the MSMA Auxiliary, and Mrs. Terrell Blanton, seated right, was named president-elect. Other officers, from left, are: Mrs. James Waites, recording secretary; Mrs. Gary Groff, fourth vice president; Mrs. Ben Martin, first vice president; and Mrs. David Owen, second vice president. Not pictured are Mrs. Enrique Flechas, third vice president, and Mrs. Ed Hill, treasurer.



Mrs. James Martin, 1982-83 president of the MSMA Auxiliary, addressed the MSMA House of Delegates.



Among the informational exhibits displayed during the 115th Annual Session was one describing the MSMA Benefit Plan and Trust. Susan Larson, director of the new program, was on hand to answer physicians' questions.



Dr. W. O. Barnett, winner of the Aesculapius Award for his scientific exhibit entitled "The Continent Ileostomy," discussed the procedure with physicians viewing the exhibits. Dr. C. Randle Voyles and the Surgical Clinic, P.A., of Jackson received second place in the judging for "Proximal Bile Duct Obstruction: New Concepts in Management." Winning the third place award was "Evaluation and Management of Severe Lower Limb Ischemia," by Drs. Charles O'Mara, Thomas H. Kilgore, and Martin H. McMullan.

Representing three of MSMA's scientific sections on the Council on Scientific Assembly are: top photo, Dr. Martha Hays of Gulfport and Dr. Alfio Rausa of Greenwood, chairman and secretary, Section on Preventive Medicine; center photo, from left, Dr. W. Joe Burnett of Oxford and Dr. Harold Hudson, chairman and secretary, Section on EENT; and bottom photo, Dr. Glenn Wegener of Clarksdale, chairman, Section on Ob-Gyn, pictured with Dr. Fred Ingram of Jackson, at right, outgoing chairman.

Council on Scientific Assembly Begins Planning for 1984

The 1984 Annual Session is set for May 16-20 in Biloxi, according to Dr. J. Elmer Nix of Jackson, chairman of the Council on Scientific Assembly. This summer the council will meet to review preliminary plans and begin work on the program for the 116th Annual Session.

The program will again include many of the popular features of past meetings, and the host hotel will again be the Royal d'Iberville.

The reorganization plan approved by delegates to the recent 115th Annual Session includes several elements which will affect the existing scientific session format. The current format, calling for separate meetings of each of MSMA's scientific sections as well as individual meetings of many state specialty societies, will be discontinued.

Under the new plan, the 14 separate scientific section meetings will be replaced with plenary sessions in surgery and medicine. State specialty societies wishing to conduct individual scientific/business meetings will continue to receive MSMA encouragement and staff support.

The surgery plenary session will be planned by representatives of MSMA's sections on surgery, EENT, ob-gyn, anesthesiology, pathology, orthopedic surgery, and urology. The medicine session will be planned by representatives of MSMA's sections on family practice, medicine, preventive medicine, pediatrics, radiology, psychiatry, and dermatology.

In a related action, delegates approved the addition of a new scientific section — the Section on Emergency Medicine.

JOURNAL MSMA will report plans for the 116th Annual Session following the upcoming meeting of the Council on Scientific Assembly.



Anxious patients improve in just a few days

And what is more reassuring to an excessively anxious patient than medication that promptly starts to relieve his discomforting symptoms? Valium® (diazepam/Roche) begins working within 30 to 90 minutes. Patients continue to improve in just a few days, and relief continues throughout the course of treatment.

There are other important benefits with Valium as well—along with its broad clinical range, Valium has an efficacy/safety profile that few, if any, drugs can match. This record has been achieved with extensive clinical experience, undoubtedly including yours. And, as you must have observed, side effects more serious than drowsiness, fatigue or ataxia rarely occur. Nevertheless, as with any CNS-acting agent, patients should be cautioned about driving, operating hazardous machinery or ingesting alcohol or other CNS-depressant drugs while taking Valium.

Yet another benefit Valium affords is flexibility.



Available in 2-mg, 5-mg and 10-mg scored tablets, Valium enables you to titrate dosage to individual patient needs. For the geriatric patient, a starting dosage of 2 to 2½ mg once or twice a day is recommended. And, for patients who forget or skip medication, you can prescribe Valrelease™ (diazepam/Roche) 15-mg slow-release capsules,

knowing that Valrelease will assure all the benefits of Valium 5 mg *t.i.d.* with the convenience of once-a-day dosage.

Discontinuation of Valium (or Valrelease) is typically as smooth as its start in short-term therapy. However, Valium and Valrelease should be discontinued gradually after more extended treatment. As you diminish dosage, the built-in tapering action of Valium and Valrelease will help avoid rapidly recurring anxiety symptoms and symptoms of withdrawal, and will help ease the patient's transition to independent coping when therapeutic goals have been achieved.

...that's one of
the unique benefits of
Valium® ^{IV}
diazepam/Roche

Valium® (diazepam/Roche)  Tablets
Valrelease™ (diazepam/Roche)  slow-release Capsules
Injectable Valium® (diazepam/Roche) 

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used IV: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly IV, it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3; administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity,

insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL: Adults: Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. the first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.) For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: *inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly IV, it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially; then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially; then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children administer IV slowly; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary; keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levetiracetam or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL: Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.





Dr. Carl Evers, speaker of the House of Delegates, briefed members of reference committees on their responsibilities at a breakfast meeting.



Dr. George Purvis, chairman of the Reference Committee on Constitution and Bylaws, reports to the House of Delegates.



Dr. Mal Morgan, chairman of the Reference Committee on Reports of Officers, Board of Trustees and Councils, gives his committee's report.



Dr. Charles R. Jenkins, chairman of the Nominating Committee, submits the committee's report to the House.



Members of the House study the reference committee reports.

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When mild
to moderate pain
is a side effect
of "Fitness"

RUFEN[®]
(ibuprofen)

measures up...
at a reasonable
cost!

**A Single-Entity Pain Reliever
As-Good-As or Better-Than Codeine
Combinations**

"...particularly effective in soft tissue disorders including sports injuries,"¹ Rufen stops pain at the site of injury and inflammation, not at the level of central perception. There is no dulled sensorium, no special need for warnings about driving or cautions about use of machinery. Your patient gets fast, effective pain relief...potent anti-inflammatory action...excellent tolerance...*plus* the exceptional economy that only Rufen offers. Next time one of your patients asks for pain relief, let Rufen show you how it measures up.



Boots Pharmaceuticals, Inc.
Shreveport, LA 71106
Pioneers in medicine for the family

See next page for brief summary of prescribing information.

Measure RUFEN® (ibuprofen) against "standard" mild to moderate pain

Dental pain and episiotomy pain are predictable, reproducible "standards" that make possible objective comparisons of effectiveness of different analgesic agents.

- Measured against 15, 30 and 60 mg doses of codeine phosphate in a double-blind study of 287 patients, 400-mg doses of ibuprofen proved "significantly better than codeine on almost all pain intensity, degree of relief and duration of analgesia parameters."²
- Measured against a propoxyphene-acetaminophen combination for pain relief after 3rd molar extractions, ibuprofen proved equally effective and caused fewer side effects. Ibuprofen was associated with faster recovery, evidenced by more rapid reduction of trismus and return to normal function.³
- Measured against post-episiotomy pain in 30 patients, "ibuprofen was effective in treating the swelling as well as pain...during the first and worst days. Therefore, it is not only the analgesic but also the anti-inflammatory effect of ibuprofen that are the beneficial factors..."⁴



Measure RUFEN® (ibuprofen) against any mild to moderate pain

RUFEN

- single-entity, peripheral-acting analgesia
- powerful treatment of both pain and inflammation
- better tolerated than aspirin

- no narcotic risk, red tape, records

- matchless economy in a modern NSAID

Acetaminophen + codeine combinations

- combined drugs act partly through central opioid pathways
- virtually no treatment of the inflammatory component
- combined side effects of two drugs—warning required about driving or operating machinery; possible respiratory depression with alcohol, tranquilizers, other common medications
- narcotic precautions required

References:

1. Hart FD, Huskisson EC, Ansell BM in Hart FD (editor): Drug Treatment of the Rheumatic Diseases, 2nd Ed, Adis Press, Balgowlah, Australia, 1982, p. 30.
2. Rondeau PL, Yeung E, Nelson P: Canad Dent Assoc J 46:433-439, 1980.
3. Selwyn P and Giles AD: Br Jrl of Clin Practice, Supplement 6, Safe and effective analgesia following dental surgery: A comparison of brufen and distalgic. Pg 87-90, 1980.
4. Taina E: Curr Med Res Opinion, 7:423-428, 1981.



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And Rufen® Measures Up Best

RUFEN® (ibuprofen) Tablets

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain. Treatment of primary dysmenorrhea.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angio-edema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS: Incidence greater than 1%. **Gastrointestinal:** The most frequent adverse reaction is gastrointestinal (4 to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS). *Incidence 3% to 9%.

Incidence less than 1 in 100. **Gastrointestinal:** gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome and alopecia. **Special Senses:** hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) (see PRECAUTIONS). **Hematologic:** neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura eosinophilia, decreases in hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Allergic:** syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasms (see CONTRAINDICATIONS). **Renal:** acute renal failure in patients with preexisting significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. **Miscellaneous:** dry eyes and mouth, gingival ulcers, rhinitis.

Causal relationship unknown. **Gastrointestinal:** pancreatitis. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri. **Dermatologic:** toxic epidermal necrolysis, photo-allergic skin reactions. **Special Senses:** conjunctivitis, diplopia, optic neuritis. **Hematologic:** bleeding episodes. **Allergic:** serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (sinus tachycardia, bradycardia, and palpitations). **Renal:** renal papillary necrosis.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease. Suggested dosage 400 mg t.i.d. or q.i.d.

Dysmenorrhea: 400 mg every 4 hours as necessary

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for the relief of pain. Do not exceed 2,400 mg per day

CAUTION: Federal law prohibits dispensing without prescription.

Medical Alumni Chapter Names Four New Board Members

Four new members have been named to the Board of Directors of the Medical Alumni Chapter of the University of Mississippi Alumni Association, according to Dr. James C. Griffin, Jr., medical chapter president.

The new board members are Dr. James N. Anderson, Montgomery, AL; Dr. Lawrence W. Mahalak, Jr., Jackson; Dr. Albert L. Meena, Jackson; and Dr. Fred L. McMillan, Jackson.

These new members will serve a three-year term, followed by another three-year term as associate members of the board.

Dr. Anderson is in private practice in general and thoracic surgery in Montgomery. He is an alumnus of Ole Miss and the Medical Center, where he also completed an internship and residency in thoracic surgery. Among his professional affiliations are the Southern Thoracic Surgical Association, the American College of Surgery and the Society of Thoracic Surgery.

Dr. Mahalak, who is in private practice in neurology in Jackson, is a graduate of Louisiana College and received his M.D. degree from UMC. After an internship at the U.S. Naval Hospital in Portsmouth, VA, he returned to UMC for a residency in neurology. A former medical officer in the Navy, Dr. Mahalak is a member of the Central Medical Society, American Academy of Neurology, and the Southern Clinical Neurological Society.

Dr. Meena is in private practice in general and thoracic surgery in Jackson and is affiliated there with the Surgical Clinic, P.A. He is a graduate of Ole Miss and the University of Indiana School of Medicine. After an internship at John Gaston Hospital in Memphis, he completed his surgical training at UMC. He is a diplomate of the American Board of Surgery and a fellow in the American College of Surgeons. Among his professional affiliations are the Central Medical Society, the American Medical Association, and the Southeastern Surgical Society. Dr. Meena has also served on the Board of Directors of the Sanders School, the Jackson Chamber of Commerce, the American Cancer Society and the Metropolitan YMCA.

Dr. McMillan is an ophthalmologist in private practice in Jackson. He is an alumnus of Ole Miss and the Mississippi Medical Center, where he also completed his internship and residency. Before opening his private practice, Dr. McMillan completed fellowships at both the Bascomb-Palmer Eye Institute and the Vitreo-Retinal Research Founda-

tion. He is a past president of the Jackson Ophthalmological Society, the Mississippi Eye, Ear, Nose and Throat Association, and the Central Medical Society.

Three Join UMC Faculty

The University of Mississippi Medical Center has added three to the medical and centerwide faculties.

Dr. Norman C. Nelson, UMC Vice Chancellor for Health Affairs and School of Medicine dean, announced the appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

Joining the centerwide faculty are Dr. John Daniel Porter, assistant professor of anatomy, and Dr. Robin William Rockhold, assistant professor of pharmacology and toxicology.

Dr. Porter, a graduate of the College of William and Mary, received the Ph.D. degree from Medical College of Virginia. He recently completed postgraduate training in physiology and biophysics at the University of Alabama in Birmingham, where he has been a fellow since 1980.

Dr. Rockhold received the Ph.D. degree from the University of Tennessee Center for the Health Sciences. He was also on staff as a graduate teaching assistant and then assistant professor of physiology and biophysics at UT. He took his postgraduate training there and at Pharmakologisches Institut, der Universitat Heidelberg.

Dr. Hans-Georg O. Bock has been appointed assistant professor of preventive medicine in the School of Medicine. Prior to accepting the UMC position, Dr. Bock was a postdoctoral fellow in pediatric genetics at the Baylor College of Medicine. He took his residency there after earning both the Ph.D. and M.D. at Vanderbilt University where he had also received his undergraduate degree.



PLACEMENT SERVICE

Situations Wanted

HEMATOLOGIST-ONCOLOGIST seeks associate or solo practice. Contact Thomas Twele, M.D., 272 Shadow Mountain, El Paso, TX 79912.

PATHOLOGIST-ONCOLOGIST seeks practice location. Frank P. Urso, M.D., P. O. Box 1149, Akron, OH 44301.

FAMILY PRACTICE resident seeks practice location in July 1983. Contact John D. Sites, M.D., 2002 Philip Dr., Muncie, IN 47302.

ANESTHESIOLOGIST seeks to relocate in state in solo, group or institutional practice. Contact M. T. Olivo, Jr., M.D., Box 794, Oxford, MS 38655.

SURGEON seeks location with established group in small city. Currently service as chief surgical resident at Ochsner Foundation Hospital. Available July 1983. Contact Thomas C. Kelly, M.D., 1516 Jefferson Highway, New Orleans, LA 70121.

PEDIATRICIAN seeks practice location in central or Gulf Coast area upon completion of residency in July 1983. Contact Steven D. Eggen, M.D., Alton Ochsner Medical Foundation, 1516 Jefferson Highway, New Orleans, LA 70121.

PATHOLOGIST seeks position in community hospital setting upon completion of residency in June 1983. Contact Robert J. Sinnenberg, M.D., Box 662 MCV Station, Medical College of Virginia, Richmond, VA 23298.

PHYSICIAN seeks ER position. Available July 1983. Contact Earl P. Wright, M.D., 218 Ternwing Dr., Arnold, MD 21012.

OTOLARYNGOLOGIST currently doing fellowship in facial plastic and reconstructive surgery. Seeks partnership or group practice in Gulf Coast area. Contact J. L. Autin, M.D., 1516 20th St. South, Birmingham, AL 35205.

Physicians Wanted

FAMILY PRACTITIONER wanted to locate in East Central Mississippi community, population 1,000 with trade area of 10,000. Clinic will be provided if desired. Contact Sandersville Health Care Services, Inc., Drawer C, Sandersville, MS 39477.

FAMILY PRACTITIONERS. Excellent private practice opportunity, well equipped 30-bed hospital in operation less than two years. Office space available in renovated clinic, 100-bed nursing home, nice community, good schools and recreational facilities, located 30 miles east of Jackson. Call (601) 732-6252 or write A. B. Farris, Jr., Mayor, P. O. Drawer 338, Morton, MS 39117.

FAMILY PHYSICIAN wanted to locate in small town in central Mississippi. Excellent private practice opportunity. Large trade area. Established clinic with all equipment, including x-ray. Call (601) 253-2321. Mayor Grady Sims, Walnut Grove, MS 39189.

FAMILY PRACTITIONER for historic Vaiden, MS. Population 1,000 with outlying area of 1,200. Located on I-55 between Jackson, MS and Memphis, TN. Ideal free office adjoining dental clinic. Our beloved physician retired. Lucrative practice, no competition; outstanding hospital (10 miles). Friendly community; fine public schools; family-like churches. Excellent housing; low taxes; hunting, fishing and trapping galore. For more details call (601) 464-8884 or write John C. Coleman, Mayor, P.O. Box 76, Vaiden, MS 39176.

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JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

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MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 19-23, 1983, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

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References: 1. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 4. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 5. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Kales JD: *Pharmacol Physicians* 4:1-6, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5:25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The

sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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July 1983, Volume XXIV, Number 7

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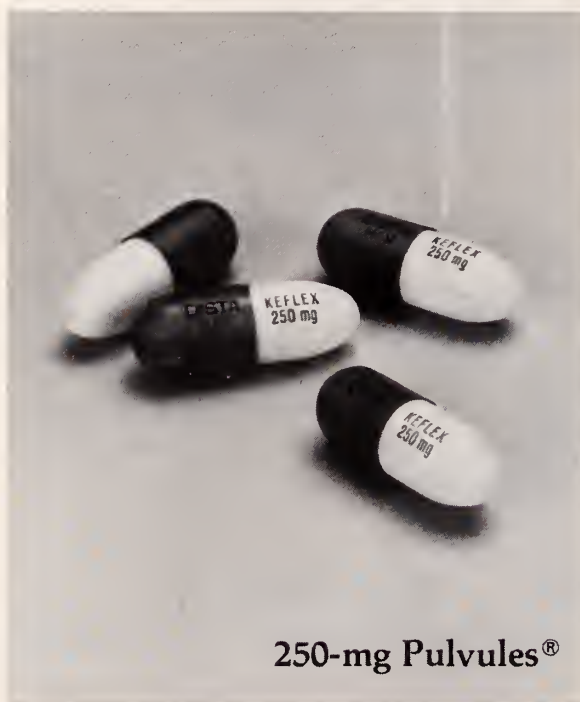
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NEWSLETTER

July 1983

Dear Doctor:

The government's top health official has called acquired immune deficiency syndrome (AIDS) the "nation's number one health problem." Edward N. Brandt, Jr., M.D., assistant secretary for health, urges physicians and health care institutions to report cases of AIDS to state health departments. He said \$14.3 million will be spent investigating the disease in fiscal 1983, more than three times the amount spent last year.

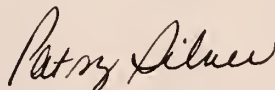
"Every physician should be aware of the possibility of AIDS when patients with malaise, weight loss, lymphadenopathy, and light fever are diagnosed," Dr. Brandt said. He also said AIDS is not a threat to the general public, noting that there is no evidence that it is breaking out from the originally defined high-risk groups.

The Reagan Administration is arguing for the reinstatement of the controversial "squeal" rule in New York and Washington, where courts have blocked the regulation. The rule requires federally funded family planning clinics to notify parents when their teen-age daughters receive prescription contraceptives. The AMA and the American College of Obstetricians and Gynecologists, along with family planning groups, object to the rule on the basis that it violates a teen-ager's right to privacy and violates patient-physician confidentiality. They also point out that fear of disclosure may lead to an upsurge in adolescent pregnancies, and teens are five times more likely to die from pregnancy and childbirth than from the use of oral contraceptives.

Sales of cigarettes have fallen substantially since the new eight-cents-per-pack federal tax increase went into effect January 1. Cigarette sales in California were down from 302 million packs in December to 166 million packs in January, and that state's cigarette tax revenues in March were some \$240,000 less than in March the previous year. Some officials say the increased cost may be encouraging many smokers to quit. Others say the drop in sales may be due to smokers having stocked up before the tax became effective.

July 19, 20, and 21 are important dates on the MSMA calendar. The MSMA and the Miss. Hospital Association are co-sponsoring seminars in Oxford, Jackson and Biloxi. The topic of discussion is Medicare's new Diagnostic Related Group (DRG) Reimbursement Program. Please contact the MSMA headquarters office if you want further information about the meetings.

Sincerely,



Patsy Silver
Managing Editor

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Physician's Handbook: Twentieth Edition. Los Altos: Lange Medical Publications, 1982. \$12.00.

Current Medical Diagnosis & Treatment. Edited by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. Los Altos: Lange Medical Publications, 1982. \$26.00.

Current Pediatric Diagnosis & Treatment: Seventh Edition. Los Altos: Lange Medical Publication, 1982. \$26.00.

Current Obstetric & Gynecologic Diagnosis & Treatment: Fourth Edition. Edited by Ralph C. Benson, M.D. Los Altos: Lange Medical Publications, 1982. \$25.00.

Principles of Clinical Electrocardiography: Eleventh Edition. Edited by M. J. Goldman, M.D. Los Altos: Lange Medical Publications, 1982. \$15.00.

Basic and Clinical Pharmacology. Edited by Bertram G. Katzung, M.D., Ph.D., Los Altos: Lange Medical Publications, 1982. \$23.50.

Handbook of Poisoning: Eleventh Edition. Robert H. Dreisbach, M.D., Ph.D. Los Altos: Lange Medical Publications, 1983. \$11.00.

Clinical Cardiology: Second Edition. Edited by Maurice Sokolow, M.D. and Malcolm B. McIlroy, M.D. Los Altos: Lange Medical Publications, 1982. \$17.50.

Stand Tall! The Informed Woman's Guide to Preventing Osteoporosis. Morris Notelovitz, M.D., Ph.D. and Marsha Ware. Gainesville: Triad Publishing Company, 1982. \$12.95.

Ten Fingers for God: The Complete Biography of Dr. Paul Brand. Dorothy Clarke Wilson. Nashville: Thomas Nelson Publishers, 1983. \$5.95.

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DATELINE

Public Approves TV Doctor Image

New York, NY - Most Americans believe that doctors are portrayed fairly in television entertainment programs. A significant number, however, perceive that video programs are presenting doctors as better than they really are. A national poll conducted by The Roper Organization for the Television Information Office reveals that 48% of the public believe doctors are portrayed fairly, while 39% consider them to be treated "too favorably."

Lawyers Seek Exemption From FTC Scrutiny

Washington, DC - The State Bar of Texas is attempting to gain an exemption from FTC jurisdiction, arguing that professions already regulated by states should not be subject to FTC scrutiny. An amendment has been introduced in the House barring the FTC from regulating "integrated" state bars, those subject to regulatory power of state supreme courts. The AMA and FTC reached agreement early this year, but pending legislation differs from the compromise language.

Surveys Rank AMA Most Influential

Chicago, IL - The AMA was named the most influential organization in the health policy arena, ranking ahead of the Department of Health and Human Services and health-related Congressional committees, in a two-year study by the University of Chicago sociology department. In a separate survey conducted by U.S. News and World Report, Dr. James Sammons, AMA executive vice president, was named the top policymaker in health.

Focus on Child Abuse and Drunk Driving

Chicago, IL - Promoting awareness and prevention of child abuse and drunk driving will be the focus of the AMA Auxiliary's 1983-84 "Shape Up For Life" campaign. The auxiliary is launching a nationwide program to help prevent child abuse, with an emphasis on community involvement in positive parenting education. Efforts for prevention of drunk driving will be directed toward legislative action strengthening and enforcing drunk driving laws.

AMA Will Contribute To Newsweek Supplement

Chicago, IL - Beginning this fall the "Personal Health Care" special advertising supplement in Newsweek magazine will include text prepared by the American Medical Association. The AMA writers will offer the magazine's 22 million readers advice on several topics, including the value of different physical exercises, suggestions for healthful eating, ways to prevent illness and cope with stress, and how to decide when to see a doctor.

PHYSICIANS . . .

Information Kits Available for counseling pregnant women

Physicians, nurses and others who counsel pregnant women are now offered a "Smoking and Pregnancy" package for use in counseling about the risks of smoking during pregnancy and the health benefits of smoking cessation.

"Because You Love Your Baby, There Has Never Been a Better Time to Quit Smoking."

According to Dr. Roland B. Robertson, Jr. of Jackson, president of the Mississippi Lung Association, the two-part program, "Because You Love Your Baby, There Has Never Been a Better Time to Quit Smoking," offers information, handbook, charts, and full color posters to health care providers for use in counseling sessions. There is also a companion package available for pregnant women which provides useful information for smoking cessation and reinforces the counselor's message.

"National statistics show that nearly half the American pregnant women do not know how smoking affects the outcome of pregnancy. It is vital that pregnant women understand the health hazards of smoking," Dr. Robertson added.

The American Lung Association created the "Smoking and Pregnancy" kits for practitioner and patient to make it possible for the busy practitioner to educate patients for "life and breath." The new program helps pregnant women understand why they should quit smoking for themselves and their babies and encourages the use of the "Freedom From Smoking" program, a self-help program for persons wanting to quit smoking.

For more information on the new "Smoking and Pregnancy" program or to order materials, contact us.

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References:

1. Stone PH, Turz ZG, Muller JE. Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104 672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al. Nifedipine therapy for coronary artery spasm. Experience in 127 patients. *N Engl J Med* 302 1269-1273, June 5, 1980.

BRIEF SUMMARY

PROCARDIA® (nifedipine) CAPSULES

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INDICATIONS AND USAGE: I. **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation; 2) angina or coronary artery spasm provoked by ergonovine; or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers, if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates. PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis. Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy. Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGPT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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once again."*

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,¹ taking fewer nitroglycerin tablets,² doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

*Quotes from an unsolicited
letter received by Pfizer from an
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ORIGINAL PAPERS

Ambulatory Eye Surgery

LYNN B. MCMAHAN, M.D.

Hattiesburg, Mississippi

IT HAS BEEN previously demonstrated that a correctly performed cataract incision will permit immediate ambulation and essentially unrestricted activity for the average cataract patient.¹ These changes, brought about by such developments as refinement of suture technique, strong nylon sutures and microsurgery, have allowed a cataract surgeon to close the wound in such a way that it will resist shearing, remain closed even with increased pressure, and rarely leak. As a result, except for anesthetic risk, hospitalization of the average cataract patient should be unnecessary. With the recent introduction of nitrous oxide analgesia, this problem has been solved and it is now possible to safely perform ambulatory eye surgery on virtually any patient regardless of age or medical condition.² This article describes ambulatory techniques used for most types of routine eye surgery and reports 500 cases.

Methods

Patient Education — Intensive patient education is very important in ambulatory surgery and is performed in a variety of ways. Our patients and their families view a video recording which follows patients through the procedure from start to finish and which includes explanations of details. These same patients are interviewed on video tape approximately one week following surgery and their reactions recorded. Most patients about to undergo ambulatory eye surgery think this is an excellent means of pa-

The author states that ambulatory techniques are well suited to most types of eye surgery, and he reports 500 cases using such techniques.

tient education. Patients are also given written material and detailed instructions regarding what to expect prior to, during, and after their surgery.

Patient Preparation — Patients are seen in the office the morning of surgery and a history is taken and physical examination is performed. Those patients with a history of serious medical problems or numerous medications obtain clearance from their primary care physicians. Before the day of surgery, patients are asked to remain NPO following a light breakfast. The day's activities are reviewed, following which the patient reports to the hospital with a packet containing the history and physical examination reports and orders. After registration, routine preoperative tests including chest x-rays, EKG, hematocrit and urinalysis are carried out.³ At the completion of tests, the patient is taken to our ambulatory preparation room where the face is washed with pHisoHex, dilating drops are instilled in the eye, and the patient changed into a hospital gown.

Anesthesia Techniques — Approximately one hour prior to surgery, the patient receives 25-50mg of Demerol® and Vistaril®. Upon arrival in the operating room, a keep-open IV is started and the patient allowed to inhale a 50% nitrous oxide-oxygen mixture for approximately five minutes. This allows the

Dr. McMahan is engaged in the private practice of ophthalmology in Hattiesburg, MS.

TABLE I
PATIENTS' AGES

30 or less	30-	40-	50-	60-	70-	80-	90-	100 or more	Total
8	3	10	58	150	176	90	4	1	500

patient to relax so that a virtually painless injection of a local anesthetic mixture of .75% Marcaine® with 2% Xylocaine® can be undertaken to block the facial nerve. This is followed by a retrobulbar injection of approximately 4 cc. (Without nitrous oxide analgesia this injection is quite uncomfortable.) After the injection, the nitrous oxide is discontinued. The nitrous clears rapidly, leaving a patient who is completely alert, responsive and cooperative. All patients are continuously monitored by CRNA with cardiac monitors in place. Upon completion of the procedure, the patient returns to the ambulatory holding room where they are allowed to sit up and receive a snack of juice and cookies. They then are permitted to dress and are discharged home.

Postoperative Instructions

Patients are encouraged to ambulate at home and allowed to eat a good supper of their choice. No routine postoperative analgesics are prescribed. The following morning, all patients are seen in the office where the bandage is removed and instructions provided on the instillation of drops and cleansing. Patients are urged to continue their daily activities as common sense dictates. They are permitted to bend, stoop, do housework, drive their car and go to work. We do ask them to restrain from heavy yardwork for approximately two weeks. In general, we ask them to do what any normal person their age would do. (One 78-year-old man wanted to know if he could ride his three-wheeled motorcycle the next day.) Patients are followed at three days, ten days, six weeks and three months at which time visions, slit lamp microscope examination and pressure checks are taken. Glasses are usually prescribed at six weeks.

Results

We report 500 patients who underwent ambulatory eye surgery using the techniques described. None of these patients were selectively chosen for ambulatory surgery. The only patients hospitalized

TABLE II
AMBULATORY PROCEDURES

XC PH IOL	449	Suture IOL	7
XC PH, no IOL	7	Discission	6
Secondary, IOL	12	IOL Exchange	2
Squint	8	Membranectomy, vitrectomy	2
Corneal transplant with IOL	3	Miscellaneous	4

Total number of cases = 500.

were those who requested to be hospitalized for insurance purposes. No patients were hospitalized for any medical reasons. Although patients of all ages were operated on, most patients fell into the elderly age range (see Table I.) One patient, a 107-year-old, walked in and out by himself with the aid of only a cane.

Three patients were admitted following surgery for complications that occurred during the procedure. Two developed PVC's noted on the cardiac monitor and were admitted for monitoring overnight. They were discharged the following morning with no further sequelae. One patient developed disorientation following a local injection and was believed to have a reaction to the drug. Surgery was cancelled, the patient was discharged the next morning, and the procedure was done as an out-patient one week later. One 76-year-old patient developed hemiparesis on the way to the office for his first postoperative visit after right cataract extraction. He was hospitalized later that day by the Neurology Department. There were no admissions among the 500 patients for any eye complications secondary to increased ambulatory activity, such as broken sutures, wound rupture or hemorrhages.

Most of the procedures performed were extracapsular cataract extractions and implantation of intraocular lenses. However, a number of corneal

transplants, secondary intraocular lense insertions and miscellaneous procedures were also performed (see Table II).

Discussion

It has been our clinical observation that ambulatory patients feel better and return more quickly to their normal activities in the mainstream of living. We think that while cataract surgery itself is not hard on the patients, taking elderly patients and placing them at bedrest for two to three days is quite debilitating. We have found that elderly patients prefer to be at home in familiar surroundings. There is excellent patient compliance with medications and follow-up appointments. Patients with numerous medications do not have their time-tables changed; diabetics do not have their diets changed.

Ambulatory surgery is ideal for eye patients. Currently hospitalization of the cataract patient is done for a number of reasons: the patient's family often

insists that the patient remain in the hospital; there is a reluctance on the part of hospital administrators, who need to keep beds full; some physicians see no reason to change a successful system; insurance companies presently deny or reduce payments to outpatients and insured patients wish to reap the most benefits. However, in the future, we should no longer have to justify ambulatory eye surgery; we may instead need to justify hospitalization for eye surgery. ★★★

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Radiologic Seminar CCXXX: Early Osteomyelitis — Demonstration of Unusual Findings on Three-Phase Bone Scan

BHARTI R. PATEL, M.D., KELLY SEID, M.D., BERNARD I. BLUMENTHAL, M.D.,
and W. MELVIN FLOWERS, JR., M.D.
Jackson, Mississippi

THE USEFULNESS of bone scan in detection of early osteomyelitis has been well established.¹⁻⁵ The diagnosis is not difficult in the presence of typical findings of increased focal activity in the area of increased early blood pool activity. The following case illustrates unusual findings on three-phase bone scan in a child with osteomyelitis.

Case Report

A 9-year-old black male was admitted to his local hospital with a history of pain in the left shoulder and a temperature of 104°F of one day's duration. His condition did not improve after three days of intramuscular antibiotic treatment. The patient was transferred to University Medical Center on the fourth day, presenting with severe left arm pain and swelling, and temperature of 104°F. The total W.B.C. count was 12,150/cu.mm. Clinically, a tentative diagnosis of cellulitis was made and the patient was placed on intravenous antibiotics. The W.B.C. count went up to 17,300 on the following day. Sick cell prep was negative.

On the second day after admission to University Medical Center, a three-phase bone scan was performed, utilizing ^{99m}Tc-methylene diphosphonate (^{99m}Tc-MDP). A rapid sequence blood flow study of the left arm was followed by immediate blood pool image of both arms. The bone scan was performed two hours post injection. The blood flow study of the left arm demonstrated increased vascularity in the upper portion of the arm (see Figure 1A). The early blood pool image (see Figure 1B) demonstrated an area of relative photon deficiency surrounded by increased blood pool activity in the re-

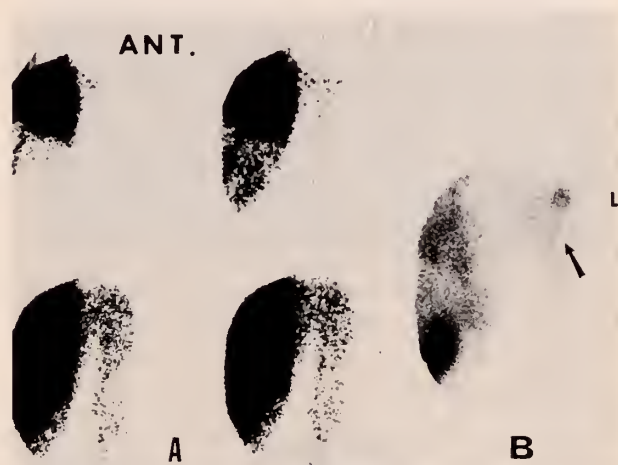


Figure 1. (A) Rapid sequence blood flow study showing focal area of increased vascularity in proximal left humerus. (B) Immediate blood pool image demonstrating a relative photon deficient area (arrow), surrounded by increased blood pool activity in the proximal left humerus.

gion of the proximal left humerus. The photon deficient area corresponded to an area of cold defect on bone scan (see Figure 2), in the proximal shaft of the left humerus.

Diagnosis of early osteomyelitis with an uncommon scan finding was made. On the blood pool image, increased activity in the soft tissue surrounding the proximal and medial aspect of the left humerus, extending distally, represented associated cellulitis. Plain radiographs on the following day showed only soft tissue swelling of the biceps extending distally without any abnormal bone findings (see Figure 3). In view of the bone scan findings of early osteomyelitis, the patient was taken to the operating room and elevation of subperiosteal space of the

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University Medical Center,
Jackson, MS.

proximal left humerus yielded gross purulent fluid. A burrhole into the medullary cavity in the proximal humerus also revealed purulent material. Glenohumeral joint aspiration was clear. Subsequent culture of the material grew *Staphylococcus aureus* which was found to be sensitive to the antibiotics with which he was currently being treated, although not sensitive to the antibiotic with which he had been treated at his local hospital. The post-operative radiographs five days later revealed periosteal reaction along the entire diaphysis of the humerus in addition to post-operative findings (see Figure 4A). The radiograph 15 days after the bone scan demonstrated evidence of active osteomyelitis which had extended the entire length of the left humerus (see Figure 4B).

Discussion

Bone imaging has played a major role in early detection of acute osteomyelitis^{1, 3, 4, 5}. The typical scintigraphic appearance of osteomyelitis is a focal area of increased activity on the bone scan in association with a corresponding area of focal increased vascularity, which can be demonstrated in flow study and immediate blood pool image.^{3, 4} Occasionally the focal area of increased vascularity is superimposed on diffuse vascularity of cellulitis.

There have been case reports of the unusual bone scan finding of a cold lesion in early oste-

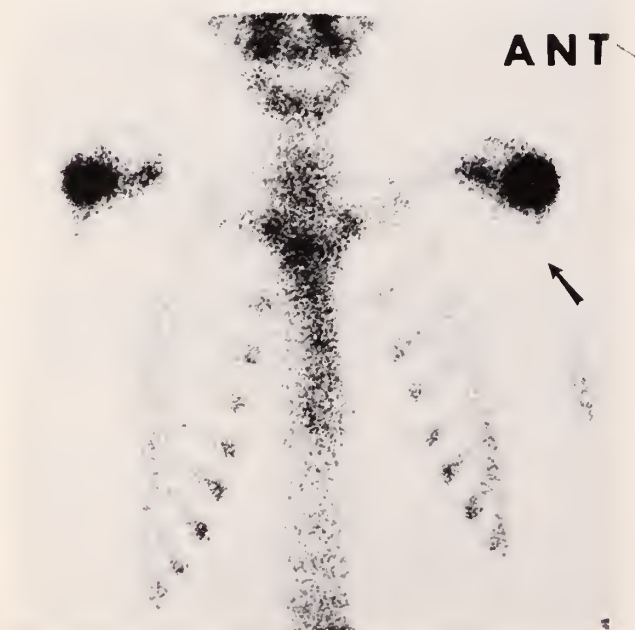


Figure 2. A cold area (arrow), seen on bone scan, corresponding to an area of relative photon deficiency on the blood pool image (which is surrounded by increased activity).



Figure 3. Radiograph of left humerus, taken the day after the bone scan, demonstrates soft tissue swelling but no bony abnormality.

omyelitis^{6, 7, 8} as well as discussion of cold defect on early blood pool findings.⁴ The combination of a photon deficient area on both the blood pool and bone scan phases of scintigraphy, as seen in our patient, is rare. Although early blood pool imaging has not always proved beneficial,⁹ in our case the flow findings and the early blood pool findings were helpful. The three-phase bone scan can be of help in differentiating early osteomyelitis from an early bone infarct. Most early bone infarcts show normal or slightly decreased blood flow and similar early blood pool findings.

The absence of activity in the involved bone on bone scan is assumed to be due to compression of microcirculation by subperiosteal and intraosseous pus.^{6, 7, 8} This assumption was proven in our case by subperiosteal and intramedullary aspiration. Osteomyelitis may or may not produce a sizeable area of ischemia, depending on the location of and mechanism of spread of infection. The common involvement of the metaphysis of long bones is thought to be secondary to their relative sluggish blood flow.⁸ The metaphyseal capillaries are termi-



Figure 4A. Radiograph of left humerus one week later, showing post surgical change in the proximal humerus and periosteal reaction along the entire shaft.



Figure 4B. Radiograph, taken two weeks after the bone scan, showing findings of osteomyelitis.

nal ramifications of a nutrient artery. In the metaphysis, the vessels form acute loops to join large sinusoidal veins. In this region, the blood flow is slow and turbulent.¹⁰ The infection spreads from the cortex to the subperiosteal region. This collection of pus is thought to be responsible for compression of microcirculation in some of the patients with a resultant cold defect on bone scan. We think the same mechanism, in our patient, is responsible for the relative photon deficient area on blood pool image.

On clinical grounds, the differential diagnosis was early bone infarction, osteomyelitis, or cellulitis. The three-phase bone scan was found to be useful in assessment of the patient's clinical condition. As noted earlier, there is a spectrum of findings on bone scan in early osteomyelitis. In our patient, interesting early blood pool findings were seen with the uncommon finding of a cold defect on bone scan.

★★★

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Address of the President

SIDNEY O. GRAVES, JR., M.D.

Natchez, Mississippi

LAST YEAR WHEN I stood at this podium to begin my year as president of our association, I was, to say the least, honored and overwhelmed. I end the year with that same feeling.

I have been deeply moved by your support. Ree joins me in expressing thanks for the many things you have done above and beyond the call of duty to make this year a memorable one for us both.

I began my state travels this year at the association's southernmost society in Pascagoula and ended the year at almost our northernmost society in Oxford.

At the beginning, the end, and in between, both in and out-of-state, I have had reaffirmed that common bond that binds us all. Namely, the deep feeling we have for the practice of medicine.

Ours is a profession of healing with a relationship to people that no other calling enjoys to the extent that we do.

I believe that relationship is, and must remain, the foundation of our profession. And this is particularly true at this time because if I had to characterize the present state of our profession, I would say it is in a period of transition.

Webster states that transition is, "passage from one stage to another."

We are in that period now with respect to medicine and most of it deals with economic considerations rather than quality of care or the physician/patient relationship, although these will no doubt be influenced by the former.

Now how did we get to this period of transition and what will the future bring?

The past two decades have seen a period of unprecedented abundance as far as health care in this country. In large part, this resulted from the fact that in 1965 Congress passed Medicare and Medicaid legislation which made billions of dollars of tax monies available to pay for medical care for the aged and poor.

President, Mississippi State Medical Association, 1982-83.
Read before the House of Delegates, 115th Annual Session,
Biloxi, May 12, 1983.

"Ours is a profession of healing with a relationship to people that no other calling enjoys to the extent that we do."

The aged and poor, in the words of supporters of Medicare and Medicaid, were put in the "Mainstream of health care."

In the private sector, the appearance of this "free care" for the aged and poor provided an impetus for increased benefits and "first dollar coverage." Blue Cross-Blue Shield and commercial insurance companies began a race to see who could outcompete each other with respect to benefits.

The result of all this gold (that doesn't glitter now) is that today on the average 90¢ of every dollar of a hospital bill and 60¢ of every physician bill is paid by a third party.

"The past two decades have seen a period of unprecedented abundance as far as health care in this country."

This increased impetus in demand for health services has been accompanied by another event. Initially as demand was stimulated by third party payments, there was a shortage of physicians. The words "we have a shortage of physicians in this country" became an article of faith and a new occupation called "health planners" began to repeat this article of faith in chorus.

The result has been that we have over 17,000 physicians graduating from medical schools this June, compared to fewer than 8,000 in 1965.

In 1965, there were 300,000 physicians in this country, today there are 525,000 and by 1986 we will have around 600,000.

At the same time, however, while the number of physicians in this country has been increasing by about 3 percent a year, the number of people has been increasing by only 1 percent a year.

In summary then, one can say that over the past 20 years, we have had an increasing number of people entitled to an increasing amount of medical care with an increasing number of physicians available to serve them.

Can this continue? The answer is no! Health care costs have gone from 5 to 10 percent of Gross National Product in this country in the last 20 years and are now competing with other demands for finite resources of the economy.

That the pinch is on can be indicated by just a few examples here at home. Medicaid this year received the same state appropriation as last year. Put another way, for the first time in the history of the program, there has been no annual increase in state funding.

On another front, the most publicized insurance program in the state this past year was called the "Cost Awareness Program." CAP (for short) is marketed by Blue Cross-Blue Shield of Mississippi and stresses high deductibles and reimbursement of out-patient rather than in-patient services.

...after all the current marketing strategies for health services and ... alphabet soup strategies for delivering health services have had their day we ... will have as our prime concern, quality medical care at a reasonable cost meeting the needs of our patients."

Economists tell us, based on the experience of other markets, that an increased price consciousness on the part of health care payors and an increased supply of physicians will have several effects on the practice of medicine.

First, more aggressive efforts will be made by physicians and other health providers to attract patients.

Secondly, the nature of medical practice opportunities will change. Such entities as preferred provider organizations, HMOs and emergency care centers are examples of this. And lastly, those of us who practice high quality medicine in the most cost-effective manner, and tailor our services to meet patient needs, will be the winners in this market.

I believe the real message in all of this is contained in the last economic viewpoint. Namely, those of us who practice high quality medical care, at a reasonable cost, tailored to meet the needs of the patient, will be winners.

I am of the opinion that American Medicine and the people we serve will not settle for less than this.

I believe that after all the current marketing

strategies for health services and after all the current alphabet soup strategies for delivering health services have had their day, we as physicians, will have as our prime concern, quality medical care at a reasonable cost meeting the needs of our patients.

"As physicians this is where our expertise lies. We must continue to be advocates of our patients and become even stronger in this regard."

As physicians, this is where our expertise lies. We must continue to be advocates of our patients and become even stronger in this regard.

We have had an opportunity to be such advocates this past year.

The year began with a number of issues on the health care agenda and it ends with many of those issues still on the agenda. We are as noted previously — in a state of transition.

One such issue concerns how much jurisdiction over the practice of medicine the Federal Trade Commission will assume in the name of regulating the profession as commerce and business. We came very close to winning this one in December when the House of Representatives voted for a moratorium on FTC regulation of the professions. Unfortunately we later lost in the Senate.

I am happy to report that, thanks to many of your efforts, our Congressional Delegation was with us 100 percent on this FTC matter. In fact, they played key roles on our behalf and we owe them a heartfelt thanks for their efforts.

Another issue that hangs heavy with us is that we still face concerns over the scope and definition of hospital privileges granted to non-physicians. The JCAH, in the name of legal considerations, and federal Medicare officials in the name of regulatory reform, are both proposing re-definition of what we know as the hospital medical staff.

Your Board and officers have opposed and will continue to oppose any expansion of medical staff privileges to non-physicians. It matters not whether the seed is planted by voluntary action or regulatory fiat, the results are the same — a lowering of standards of health care.

Now if the scenario that I have described so far makes you angry and increases your adrenaline, it should.

But I find that when we are angry and our adrenaline is flowing, we are at our best for action. And action is what we need.

(Continued on page 193)



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The President Speaking

"The Greatest Show on Earth"

Whitman B. Johnson, Jr., M.D.
Clarksdale, Mississippi

P. T. Barnum called his circus "The Greatest Show on Earth," and some claim that this title now belongs to the Democratic National Convention. I disagree with both. I am convinced the title should go to the Annual Session of the American Medical Association. It is the equivalent of a six-ring circus, particularly this year with the big tiger, Ronald Reagan, in attendance.

Everyone was greeted at the hotel with champagne and soft drinks. Late every afternoon and evening the various state associations and medical sections opened hospitality rooms where they nourished, numbed, and nudged you for the benefit of their candidates. The larger states put on huge parties every night and luncheons were held at noon. The handouts at the various functions varied from "stick-on" labels and buttons to bottles of wine and ball point pens with digital watches on them. Before the convention was over, due to the weight of the "stick-ons" and buttons, everyone was listing to the side of their badges.

As the days wore on, the secret service people became more and more in evidence for the arrival of Mr. Reagan. His appearance was almost anticlimactic and his speech was pure apple pie and motherhood, but he did make the traffic on Michigan Avenue grind to a trickle. So much for the side shows.

In the main arena a lot of important matters, and some not so important, were discussed. The entire theme was holding down costs without sacrificing quality in view of all the expected changes. It was amazing to see the care necessary in wording the final resolutions because of a permanent injunction against the AMA since 1943 having to do with restraint of trade. The tight rope walker, Dr. James Sammons, AMA executive vice president, had frequent consultations with the legal staff and advised the delegates how to avoid any appearance of conflict with the injunction.

The major issues concerning us as practicing physicians were the Joint Commission's interpretation of "medical staff," medical manpower, competition, foreign medical graduates (which became an emotional issue on the floor), guidelines for free-standing "emergency clinics," the possibility of endorsing indemnity coverage instead of "usual, customary, and reasonable" fees, and what the future holds for the physician under Diagnostic Related Groups reimbursement. As one delegate put it, "It reminds me of a mother telling her teenage daughter that when her boyfriend said to her, 'Trust me, trust me,' don't do it — you know what will happen. Now the government is saying 'Trust me, trust me,' and we all have a good idea of what is going to happen."

All in all, the AMA Annual Session was an interesting and gratifying experience. ★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXIV, Number 7

JULY 1983

"Thanks, Moncure, For a Job Well Done!"

Dabney Named Editor Emeritus

At the recent Annual Session of the Mississippi State Medical Association. Dr. Moncure Dabney of Crystal Springs relinquished his post as Editor of this JOURNAL, a position he had held for some twenty-two years.

During this period, Dr. Dabney led the editorial staff in a quiet, yet very proficient manner, always working to improve what you the members of this association receive in the JOURNAL. During his tenure, the JOURNAL steadily advanced in quality and ranked high among state medical journals.

In honor and appreciation of his many years of dedicated service, the House of Delegates, at the 115th Annual Session, voted in favor of a resolution naming Dr. Dabney as Editor Emeritus.

While this very appropriate action was taken by your representatives in the House of Delegates, I could not let this action get by without calling it to the attention of all the members of the society.

This matter is too important to get lost in the lengthy records of the society and not be appreciated by all of you. I know each and every member of this society joins me in saying, "Thanks, Moncure, for a job very well done."

MYRON W. LOCKEY, M.D.
Editor

Address of the President

(Continued from page 190)

We had a fairly successful year with the Mississippi Legislature, thanks to Bucky's efforts and your response to those efforts with your local senators and representatives. Based on your response though, we are operating at about 50 percent capability. Think what we could do if we could raise this to 75 or 90 percent.

Most of the issues that I have spoken about today

will finally be influenced or resolved by actions of the Mississippi Legislature.

Now this is an election year in our state. I don't expect all of us to make that ultimate sacrifice that Faser Triplett and Barbara Blanton have made and some others are thinking about. Namely, running for the legislature. But colleagues, the time is right for you to put your money where your mouth is if you believe that we must be advocates for our patients and must have quality health care at a reasonable cost for all Mississippians.

The time is right and your candidate for the Mississippi Legislature will never listen more closely to your views that only a physician should practice medicine than he or she will this year.

Do you have a candidate? Based on your contributions to the Mississippi Medical Political Action Committee and your response to calls for contacting your current legislators, I would say about 50 percent of you do.

Fifty percent is not enough! This period of transition requires more.

In closing, let me note that it's the president's prerogative to end his year with several recommendations for your consideration. I do not intend to miss this opportunity.

I propose first that we reaffirm and publicize to the membership the prior action of this House of Delegates recommending that each hospital staff in this state encourage selection of a physician from that staff to sit on the hospital's governing board.

Next, I propose that the Board of Trustees and Council on Legislation review a law passed in Ohio last year defining who has hospital admitting privileges and consider the feasibility of seeking enactment of such a law in our state.

Finally, I recommend that the president's annual allotment be raised to \$2,000, effective with my successor in office.

Again, let me thank you for the privilege of holding this office. It has been an honor I will always cherish.

★★★

COMMENT

Rx for physicians

The president of the American Medical Association, Dr. William Rials of Swarthmore, Pa., recently expressed concern — in an address at the Mississippi State Medical Association convention — over what he called the medical profession's "terrible" image problem. But it is not one physicians cannot "treat."

The problem is largely a consequence of the high cost of health care generally and of the services of doctors in particular, and of a perception by many people that physician care is excessively ordered for the convenience of physicians.

Patients bear some responsibility — in taking up a doctor's time on negligible or imagined ailments; in demanding unnecessary tests, treatment or hospitalization; and in the tendency of jurors to award excessive damages in malpractice suits. And a small minority of both doctors and patients have ripped off the Medicare and Medicaid systems.

What can be done? Dr. Rials properly suggested that doctors should not become so charmed by sophisticated equipment that they forget the concept of "compassionate care." Certainly patients might feel more kindly disposed if they didn't feel they were willy-nilly being lined up in hospital rooms to be visited on an assembly line basis regardless of the nature or seriousness of their illness.

As for costs, medical care is probably the only thing on the market in which the price can essentially be set arbitrarily by the supplier.

As the image problem cannot be separated from costs, doctors would be well advised to use their influence to help advance any proposal that might reduce those costs.

For example, President Reagan has sent to Con-

gress legislation designed to lower the double-digit inflation that is threatening to put health care out of the reach of many. The Reagan proposal would increase the rewards for practicing efficient medicine and also offer changes that would give consumers, large hospitals, and employers and unions buying group health care coverage incentives to be cost-conscious.

One of the Reagan recommendations would restructure Medicare benefits to offer more protection to those who are most ill and have longest hospital stays. Under current law, Medicare hospital coverage may expire just when it is needed most, during a catastrophic illness. The change would provide for moderate co-payments earlier in the hospitalization, now paid in full by Medicare, when a patient can better afford it. Also, such outlays are likely to discourage unnecessary hospitalization.

If doctors show themselves both more disposed to be sensitive to the cost of their services on a personal level and more interested in collectively supporting any government initiatives that would hold down the escalation of costs, their traditional image would be remarkably improved.

(Ed. Note: The above editorial is reprinted from the May 30 edition of the Jackson Clarion-Ledger. JOURNAL MSMA welcomes your comments on this or any other medical practice issue.)

LETTERS

SIRS: On behalf of the Board of Directors and volunteers of the Mississippi Lung Association, we take this opportunity to thank you and your staff of the MSMA JOURNAL for your great cooperation with the new American Lung Association Smoking and Pregnancy Program.

The response from your most recent Journal announcing the new program has been outstanding. The physicians and clinics have phoned and written asking for information about the new program and we are indeed grateful to you for this help to reach our Mississippi medical persons who counsel expectant mothers.

Again, our very special thanks for this most generous public service. We appreciate your editorial and ad support for a new and most valuable program.

JUDSON J. ALLRED, JR.
Executive Director



JOIN **MPAC** TODAY

MEDICAL ORGANIZATION

Dr. Lockey Named Editor of Journal MSMA

Dr. Myron W. Lockey of Jackson, associate editor of JOURNAL MSMA since 1973, was elected editor during the MSMA's 115th Annual Session. He succeeds Dr. W. Moncure Dabney of Crystal Springs, who was named editor emeritus.

Dr. Dabney had been editor of the JOURNAL since 1961, and delegates to the Annual Session approved a resolution naming him editor emeritus and expressing appreciation for his 22 years of service in the post.

Dr. Joseph E. Johnston of Mt. Olive was elected associate editor. Dr. Johnston has edited the *Magnolia State Family Physician*, published by the Mississippi Academy of Family Physicians, since the quarterly publication was established in 1979.

Also on the JOURNAL MSMA editorial board is Dr. Arthur A. Derrick of Durant, who was elected associate editor in 1982.

The three editors are members of the MSMA's Committee on Publications, which oversees production of JOURNAL. Three other members of the committee are appointed by the Board of Trustees, and include Dr. Lawrence W. Long, chairman, Dr. W. H. Lotterhos, and Dr. George H. Martin.

Dr. Hillman Appointed To AMA Advisory Committee

Dr. Joseph C. Hillman of Brookhaven has been appointed to the Advisory Committee of the American Medical Association's Health Policy Agenda for the American People.

Dr. Hillman will represent the Mississippi State Medical Association on the national panel, established in 1982 for the purpose of developing a long-term, consistent approach to health issues facing the nation.

The Health Policy Agenda (HPA) is a three-year project which involves representatives from many groups concerned with health care, including, among others, practicing physicians, nurses, dentists, hospitals, third party payors, state and federal government, medical schools, medical students,

specialty societies, pharmacists, osteopaths, business and labor.

Dr. Hillman completed his undergraduate education at Mississippi State University. He received his M.D. degree from the University of Mississippi School of Medicine, where he served as president of his class for three years and as student body president. Part of his training was completed at Oxford University Medical School in Oxford, England. He completed a residency in family practice at University Medical Center in Jackson.

Dr. Hillman is a former member and chairman of MSMA's Council on Medical Service, and he was a participant in the Mississippi Economic Council's Human Resources Seminar.

Dr. Watkins Receives Distinguished Service Award



Dr. Clyde A. Watkins of Jackson received the Mississippi Lung Association's 1983 Distinguished Service Award. Dr. Roland B. Robertson, Jr., president of the MLA, expressed appreciation for Dr. Watkins' long time dedication to the crusade for "life and breath" in Mississippi. For 30 years Dr. Watkins was superintendent of the Mississippi State Sanatorium, and until his recent retirement he was medical consultant to the Tuberculosis Control Unit of the State Health Department.



Dr. Charles Lamar Daley, Jr., center, earned the M.D. summa cum laude in University of Mississippi Medical Center Commencement ceremonies May 29. The son of Mr. and Mrs. Charles L. Daley, Sr., of Jackson, Dr. Daley received the School of Medicine's Waller S. Leathers Award as the graduating medical school senior with the highest academic average for four years. Dr. Porter L. Fortune, Jr., left, is University of Mississippi chancellor, and Dr. Norman C. Nelson, right, is UMC vice chancellor and dean of the medical school.

UMC Commencement Speaker Urges Prevention Goals

Dr. Robert D. Sparks told University of Mississippi Medical Center graduates Sunday that "different priorities must be applied in their personal and professional lives if they are to be effective in controlling and preventing today's important diseases."

Dr. Sparks, who is president, chief programming officer and trustee of the W. K. Kellogg Foundation, said that more than 400,000 Americans die prematurely from preventable illnesses caused by cigarette smoking and alcohol abuse.

He challenged the UMC graduates to make the goal of their professional lives as health practitioners to "apply the principles and practices of public health and disease prevention to overcome the preventable diseases and accidents."

Three hundred and forty Medical Center students received degrees in the health sciences at the City Auditorium. The number included 138 who received the M.D.; 92 the B.S. in nursing; 37 the D.M.D.; 1 the B.S. in cytotechnology; 11 the B.S. in medical record administration; 7 the B.S. in medical technology; 9 the B.S. in nurse anesthesiology; and 26 the B.S. in physical therapy. Also, 8 for the M.S. in nursing; 3 for the M.S.; 1 M.C.S.; and 7 for the Ph.D.

Chancellor Porter L. Fortune, Jr., conferred degrees. Candidates were presented by Dr. Norman C.

Nelson, vice chancellor and School of Medicine dean; Dr. Edrie J. George, School of Nursing dean; Dr. Thomas E. Freeland, School of Health Related Professions dean; Dr. Wallace V. Mann, School of Dentistry dean; and Dr. Ben H. Douglas, assistant vice chancellor for graduate studies.

Charles Lamar Daley, Jr., son of Mr. and Mrs. Charles L. Daley, Sr. of Jackson, was recognized as the top medical school graduate. Dr. Daley, who earned his degree summa cum laude, received the University's Leathers Award as the graduating medical student with the highest academic average. Dr. Daley will intern at the University of California Hospitals in San Francisco. He completed undergraduate work at the University of Mississippi.

Magna cum laude graduates in the School of Medicine were Nancy Sharon Martin and Donald R. Watson, both of Jackson, and Carol Jean Mitchell of Plantersville.

Cum laude medical school graduates included Norman Keith Ashburn and Dale Alexander Touchstone of Clinton, David J. Byler of Jackson, Eric Mason Dyess and Bobby L. Graham, both of Meridian, and Murray Pinkston Whitaker of Vicksburg.

UMC Students Select Outstanding Professors

Students in the University of Mississippi School of Medicine at the Medical Center have selected Dr. Lloyd B. Gallimore, Jr. and Dr. Bernard J. Dreiling as Professors of the Year.

The awards, made possible by the Medical Alumni Chapter of the University of Mississippi Alumni Association, consist of \$500 prizes in recognition of teaching excellence.

Dr. Gallimore, selected by the sophomore class, was named preclinical professor of the year. The assistant professor of anatomy earned the M.S. and Ph.D. at Bowman Gray School of Medicine of Wake Forest University where he was an instructor in anatomy prior to his Medical Center appointment in 1975. He is a member of Sigma Xi and his major research interest is in the importance of the kidney as a component in the regulation of calcium homeostasis.

Dr. Dreiling, named clinical professor of the year by the seniors, is associate professor of medicine. A hematologist at the Veterans Administration Medical Center, he earned the M.D. at St. Louis University School of Medicine in St. Louis, Missouri, and also completed his residency training there. He did a fellowship in hematology at UMC. He is a fellow in the American College of Physicians.

Medicare Payment Program — DRG Is Coming

On October 1, 1983, Medicare will begin a three-year, phased-in program to limit payment to hospitals to a prospectively determined amount per each Medicare patient's hospital discharge. Discharges will be classified into Diagnostic Related Groups (DRGs).

Medicare will use 356 DRGs. These will be divided into 23 Major Diagnostic Categories (MDCs), which are clustered according to organ systems.

The new program requires hospitals to maintain data that combines medical record and hospital billing information per patient discharge. A rather complex data analysis and evaluation system is used to determine the maximum amount Medicare will pay a hospital for a hospital stay for a given diagnosis. The hospital will not be permitted to charge Medicare patients any additional amount. There also are barriers to shifting hospital charges to Part B of Medicare (physicians).

This new Medicare law has other serious implications for physicians, patients, hospitals, and private third party payers. Studies and reports are required to:

- Develop data and make recommendations by January, 1985, for payments to physicians under DRGs.
- Report on feasibility of applying DRG system to all payers — public, private insurance, and individual paying patients; and publish information on payment rates of public and private payers.

For the present, hospitals are compelled by economic necessity to explain this new DRG Medicare payments system to physicians and obtain their understanding and cooperation. As this proceeds, new vocabularies of management systems, accounting methods and production/marketing processes are inevitable. Quality of medical care factors, patient relationships, and professional liability considerations will be important issues as the new payment system is installed in hospitals.

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

PERSONALS

JAMES ACHORD of UMC spoke at a meeting of the West Mississippi Medical Society in Vicksburg and attended recent planning meetings for the American College of Gastroenterology in Chicago and New York.

ORLANDO J. ANDY of UMC presented papers at the Washington, D.C. meeting of the American Association of Neurosurgical Surgeons and at the recent American Stereotactic and Functional Neurosurgical Society meeting in Durham, North Carolina.

BLAIR BATSON of UMC attended a recent meeting of the National Board of Medical Examiners in Washington, D.C.

JOSEPH H. BOGGESS announces the opening of his office for the practice of ear, nose and throat at 2461 Fifth Street North in Columbus.

JAMES M. DAVISON announces the opening of his office for the practice of obstetrics and gynecology at 2041 Shiloh Road in Corinth.

LARRY H. DAY of Hattiesburg has been named president-elect of the Louisiana-Mississippi Ophthalmological and Otolaryngological Society.

ROBERT H. DONALD of Pascagoula received the Others Award presented by the Salvation Army and also received an award of special recognition presented by the Pascagoula City Council.

EDGAR DRAPER of UMC served as examiner for the American Board of Psychiatry and Neurology in New Orleans and was in New York for the American Psychiatric Association meeting, where he chaired a panel and presented a paper.

GENE GADDY announces the opening of his office for the practice of ophthalmology at 1213 31st Street in Gulfport.

WOOD HIATT of UMC recently spoke at an organizational meeting for a Jones County child abuse prevention society.

JOHN JACKSON of UMC recently was a consultant to the Louisiana Board of Regents Research and Development program in New Orleans.

RICHARD KUEBLER has associated with the Street Clinic in Vicksburg for the practice of radiology.

PERSONALS/Continued

PATRICK H. LEHAN of Jackson recently received the Achievement Award of the American Heart Association, Mississippi Affiliate.

THOMAS MCFARLAND of Purvis has associated with Emergency Physicians of Hattiesburg, PA.

GEORGE W. MOSS of Natchez has been recertified by the American Academy of Family Physicians.

JOHN C. MUTZIGER announces the opening of his office for the practice of family medicine at 913 Holland Avenue in Philadelphia.

WILLIAM NICHOLAS of UMC conducted a seminar in Hattiesburg for the Mississippi Affiliate, American Diabetes Association, and was guest speaker at a meeting of the Tupelo Chapter of the association.

MAURICE G. PREVOST announces the opening of his office for the practice of otolaryngology at 965 Avent Drive in Grenada.

MICHEL RIVLIN of UMC presented a paper at the First World Conference on Fallopian Tubes in West Palm Beach, Florida, and at the Atlanta meeting of the American College of Obstetricians and Gynecologists.

MARY J. WARD of Corinth announces the association of MARTA HANS in the practice of pediatrics and adolescent medicine.

WINFRED WISER of UMC spoke at a recent meeting of the Southeastern Ob-Gyn Society in Hamilton, Bermuda.

NEW MEMBERS

ALQUEZ, M. B., Jackson. Born Philippines, May 2, 1940; M.D., Southwestern University, Cebu City, Philippines, 1963; interned and pediatric residency, University Medical Center, Jackson, 1977-80; elected by Central Medical Society.

GRILLO, DONALD, Jackson. Born New York, Sept. 9, 1933; M.D., Albany Medical College of Union University, Albany, NY, 1959; interned Albany Medical College, one year; ob-gyn residency, Fitz-

simmons General Hospital, Denver, CO, 1964-67; elected by Central Medical Society.

HOWARD, WILLIAM P., Jackson. Born Canton, MS, Dec. 29, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1979; interned and family practice residency, University Medical Center, Jackson, MS, 1979-82; elected by Central Medical Society.

HOWELL, SHELBY C., Clarksdale. Born Clarksdale, MS, Sept. 15, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned Baptist Memorial Hospital, Gadsden, AL, one year; elected by Clarksdale and Six Counties Medical Society.

HUDSON, CLAYTON N., Vicksburg. Born Birmingham, AL, April 29, 1938; M.D., University of Alabama School of Medicine, Birmingham, 1973; interned and surgery residency, Lloyd Noland Hospital, Fairfield, AL, 1973-77; general surgery fellowship, Cleveland Clinic, Cleveland, OH, 1982-83; elected by West Mississippi Medical Society.

JETT, PAMELA L., Vicksburg. Born Owensboro, Ky, Jan. 18, 1954; M.D., University of Louisville School of Medicine, Louisville, KY, 1979; interned and pathology residency, Shands Hospital, Gainesville, FL, 1979-83; elected by West Mississippi Medical Society.

LUCAS, JOHN F., III, Greenwood. Born New Orleans, LA, Oct. 24, 1955; M.D., Duke University School of Medicine, Durham, NC, 1981; interned and general surgery residency, same, 1981-83; elected by Delta Medical Society.

MARTIN, FRANK G., Biloxi. Born McComb, MS, Aug. 8, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned Mobile General Hospital, Mobile, AL, one year; general surgery residency, University of South Alabama, Mobile, 1973-77; elected by Coast Counties Medical Society.

TOUCHSTONE, W. C., Belzoni. Born Harperville, MS, June 5, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1965; interned Baraness Erlanger Hospital, Chattanooga, TN, one year; elected by Delta Medical Society.

WHITE, JAMES O., Batesville. Born Jackson, MS, Aug. 11, 1947; M.D., University of Mississippi Medical School, Jackson, 1973; interned and pediatric residency, University Medical Center, Jackson, MS, 1973-76; elected by North Mississippi Medical Society.



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Grant Will Fund Stroke Research at UMC

The University of Mississippi Medical Center has received a \$22,000 grant from the Ernestine Peck Vaughan Stroke Research Trust.

The Trust was made possible by the late Mrs. Ernestine P. Vaughan of Columbus, who designated that the earnings from five percent of her estate be used for research on paralytic stroke.

Dr. Robert D. Currier, professor of neurology, department chairman, and chairman of the Medical Center's Stroke Committee, points out that stroke is the third leading cause of death in the United States. In Mississippi, it's exceeded only slightly by cancer and heart disease.

"We've long known that strokes are more common in the South, especially in our state," he said, "but we have no conclusive data as to why. More research is thus obviously needed. Stroke takes a heavy, heavy toll in Mississippi each year — in both death and disability."

Dr. Currier said the \$22,000 Vaughan grant will be used to fund two three-month student fellowships this summer in stroke research; to pay one half of a registered nurse's salary to teach stroke care and supervise the Department of Neurosurgery's hyperbaric chamber; to purchase needed laboratory equipment for the UMC stroke research laboratory department of Neurosurgery which is being designated the Vaughan Stroke Research Laboratory; and to provide a small fund from which to award competitive grants on strokes within the Medical Center.

"We hope to get matching funds for the money set aside for the student fellowships and for the intra-institutional grants," Dr. Currier said. "There may be individuals, businesses, even civic clubs, who may wish to assist in our various programs for stroke research. Matching the Vaughan grant will be a significant step in that direction."

Members of the Medical Center Stroke Research Committee in addition to Dr. Currier include Dr. Robert R. Smith, professor of neurosurgery and department chairman; Dr. John P. Kapp, associate professor of neurosurgery; Dr. Armin F. Haerer, professor of neurology; Dr. A. Wallace Conerly, assistant vice chancellor; and Dr. Michael Duckworth, a Columbus physician.

Medico-Legal Brief

Association Ordered To Reinstate M.D.

A trial court properly ordered a county medical society and a state medical association to reinstate a physician to membership because of failure to follow fair procedures in a disciplinary proceeding, a California appellate court ruled.

The physician was a member of the county society, a component society of the state medical association. It was governed by the constitution and bylaws of the state association on matters of discipline. In May 1975, the credentials and professional review committee of the county society filed charges against the physician. He was served with a copy of formal charges and notice of hearing on the charges.

A hearing was conducted before the judicial council, which was composed of the same persons who had conducted the preliminary hearings and decided that formal charges should be filed. The council was advised that the burden of proof was by a preponderance of the evidence, contrary to the bylaws that required clear and convincing proof. The council found against the physician on several charges, including false statements and deficiencies in professional competence. After the council directed that he be expelled from the county society, he appealed to the state association.

The written decision of the state association stated that it conducted an independent review of the case and applied the proper clear and convincing proof standard. The association ordered expulsion, but stayed it and ordered probation for a year. A year later the county society determined that he had not complied with the terms of the probation and expelled him.

In the meantime, the state board of medical quality assurance filed an accusation against the physician. The board found him guilty of one incident of overprescribing, one incident of ordering excessive laboratory procedures, and one incident of overbilling Medicare. His license was ordered suspended for six months, but the suspension was stayed and he was placed on probation for two years. A trial court affirmed, but the appellate court remanded the case to the board. Only one of the charges was supported by the evidence and the disciplinary measure should be redetermined.

The physician appealed the decision of the medical society to a trial court, which ordered the two organizations to reinstate him. On appeal, the appellate court said that the concept of fair procedure applied the the society's decision. The court said that

the physician was denied a fair hearing because he was given no practical way to determine whether the members of the judicial council were impartial and the committee held executive sessions from which he and his counsel were excluded. The committee was also incorrectly charged on the burden of proof established by the society's bylaws.

The fact that the state medical association did not repeat the procedural defects in the society's proceeding did not cure the defects, the court said. The proceedings before the board of medical quality assurance did not prohibit further disciplinary proceedings by the society. Neither the society nor the state association were parties to that proceeding the court noted.

Since the proceedings violated fair procedure, the trial court's reinstatement order should be affirmed, the court concluded. — *Hackethal v. California Medical Association*, 187 Cal.Rptr. 811 (Cal.Ct. of App., Dec. 7, 1982)

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FAMILY PRACTICE resident seeks practice location in July 1983. Contact John D. Sites, M.D., 2002 Philip Dr., Muncie, IN 47302.

ANESTHESIOLOGIST seeks to relocate in state in solo, group or institutional practice. Contact M. T. Olivo, Jr., M.D., Box 794, Oxford, MS 38655.

PHYSICIAN seeks ER position. Available July 1983. Contact Earl P. Wright, M.D., 218 Ternwing Dr., Arnold, MD 21012.

SURGEON seeks location with established group in small city. Currently service as chief surgical resident at Ochsner Foundation Hospital. Available July 1983. Contact Thomas C. Kelly, M.D., 1516 Jefferson Highway, New Orleans, LA 70121.

PEDIATRICIAN seeks practice location in central or Gulf Coast area upon completion of residency in July 1983. Contact Steven D. Eggen, M.D., Alton Ochsner Medical Foundation, 1516 Jefferson Highway, New Orleans, LA 70121.

PATHOLOGIST seeks position in community hospital setting upon completion of residency in June 1983. Contact Robert J. Sinnenberg, M.D., Box 662 MCIV Station, Medical College of Virginia, Richmond, VA 23298.

PATHOLOGIST seeks location in Mississippi. M.D., Ohio State University; residency, University of Alabama. Contact Janice Blazina, M.D., 2323 DeLee St., Apt. 31, Bryan, TX 77801.

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IN CONCLUSION

Last year was the best year yet for the HMO industry, according to a four-year financial study prepared for the Dept. of HHS. Commenting on the study, an HHS official said, "HMOs are in the mainstream." He noted that New Orleans is the only city with a population of one million that does not have an HMO. Last year 48 of the nation's 60 largest HMOs earned \$51.2 million on record revenues of \$2.1 billion. The report also said 90% of the plans were operating profitably, compared with 1979, when only 50% were profitable.

Customers cannot rely on the accuracy or safety of health and nutrition advice they may receive from health food store personnel, the American Council on Science and Health has warned. Undercover investigators, often complaining of potentially dangerous medical symptoms, found that most of the sales people failed to recommend consulting a physician. They often attempted to diagnose the ailment and recommend treatment, and often gave hazardous, as well as inaccurate, advice.

The clinic that pioneered and perfected the coronary artery bypass graft for heart patients now offers a plan to help contain the costs of that surgical procedure. Floyd D. Loop, M.D., and colleagues from the Cleveland Clinic Foundation report in the July 1 JAMA that they were able to realize a 10% saving in hospital charges for a control group of 25 patients. Savings resulted from such procedures as carrying out workups on an outpatient basis and decreasing special care unit time.

Physicians have an exemplary history of treating Medicare beneficiaries on an assignment basis, the American Medical Association told the U.S. Advisory Council on Social Security. In 1982, 52.8% of all claims were on an assignment basis, and 54.2% of total charges were assigned. More widespread acceptance of assignment could best be accomplished by making the reimbursement level more acceptable and in accord with usual and customary practices, and by expediting the billing and claims process, the AMA said.

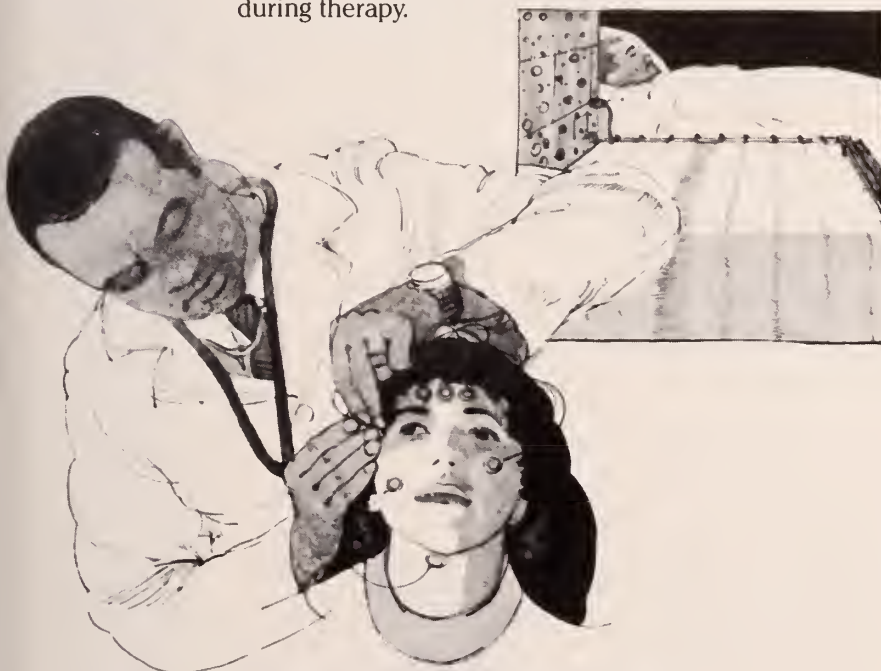
Many state and county medical societies have abandoned fee review and grievance committee activities for fear of intervention by the FTC, the AMA told the Senate Commerce Committee. An informal AMA survey found 12 societies that have eliminated fee review and four that have given up disciplinary activities on the advice of attorneys. The survey did not cover all state and county societies. "The public is disadvantaged when such activities are abandoned," AMA board chairman Joseph F. Boyle, M.D., told the committee.

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References: 1. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 4. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 5. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Kales JD: *Pharmacol Physicians* 4:1-6, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5:25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The

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NEWSLETTER

August 1983

Dear Doctor:

The Mississippi Medical Political Action Committee (MMPAC) received three awards from AMPAC during the MSMA's recent 115th Annual Session in Biloxi, and the June issue of Journal MSMA contained an error in the identification of those awards. In the annual membership awards, MMPAC received a first place in average contributions per member, first place in number of sustaining members, and second place in the all events category.

Mississippi placed second only to California in the all events category. Indiana received the third place award, rather than Mississippi, as reported in the Journal. Dr. William Y. Rial, AMA president, presented the awards to Dr. J. O. Manning, MMPAC chairman, during the House of Delegates session.

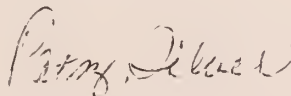
JAMA, celebrating its 100th anniversary this year, continues to expand into foreign countries, both in the English language and in other languages. JAMA now has a weekly circulation of 322,000 copies in English to 132 countries and 121,000 copies with varying frequencies of publication in six other languages in six countries.

The FDA has withdrawn its controversial proposed rule that would have restricted the sale, distribution and use of alpha-fetoprotein (AFP) test kits for detection of possible neural tube defects which include spina bifida and other major birth defects. The kit is expected to become available after approval of its labeling and patient information brochures.

Hospital rates across the country, as surveyed by the Equitable Life Assurance Society of the U.S., averaged \$171.50 for a semi-private room in 1982. National average rate for a private room was \$167.50. Mississippi hospitals averaged \$99 for a private room and \$96 for a semi-private room. Mississippi's increase in rates was 5.01% lower than the national increase, the survey showed.

Later this month the Council on Scientific Assembly will hold its annual meeting to begin planning for the 116th Annual Session. Representatives of MSMA's 15 scientific sections (now including the new Section on Emergency Medicine) will make plans according to a number of format changes authorized last May by the House of Delegates. Next year's meeting is set for May 16-20 in Biloxi.

Sincerely,



Patsy Silver
Managing Editor

MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 17-21, 1984, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

Mississippi State Medical Association, 116th Annual Session, May 16-20, 1984, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 13-17, 1984, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39221.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November, H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clark, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Richard C. Carter, Pres. and Secy., 314 W. Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. S. B. Fineberg, Sec'y., 2204 Old Mobile Hwy., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Pendergrass, Secy., 201 Hospital Dr., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

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North Mississippi Medical Center 830 Gloster Avenue Tupelo, MS 38801	Northwest Mississippi Regional Medical Center Box 1218 Clarksdale, MS 38614
Forrest General Hospital Box 1897 Hattiesburg, MS 39401	Mississippi Chapter American College of Surgeons Box 5229 Jackson, MS 39216
Mississippi Baptist Hospital 1225 N. State Street Jackson, MS 39201	Mercy Regional Medical Center 100 McAuley Drive Vicksburg, MS 39180
Gulf Coast Community Hospital 4642 W. Beach Boulevard Biloxi, MS 39531	North Panola County Hospital Drawer 160 Sardis, MS 38666
Jefferson Davis Memorial Hospital Box 1488 Natchez, MS 39120	Singing River Hospital 2809 Denny Avenue Pascagoula, MS 39567
King's Daughter Hospital Box 948 Brookhaven, MS 39601	Magnolia Hospital Alcorn Drive Corinth, MS 38834
Delta Medical Center Greenville, MS 38701	Greenwood Leflore Hospital 1508 Leflore Avenue Greenwood, MS 38930
Riverside Hospital Lakeland Drive Jackson, MS 39208	South Washington County Hospital Drawer 398 Hollandale, MS 38748
Biloxi Regional Medical Center 1559 Lafayette St. Biloxi, MS 39533	Memorial Hospital 4500 13th Street Gulfport, MS 39501

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DATELINE

Toll-Free Line For Organ Donor Referrals Jackson, MS - A new 24-hour, toll-free telephone number is available for use by physicians and other health professionals throughout North America for organ donor referrals. The number, 800-243-6667 (800-24D-ONOR), will put the caller in contact with the closest, most appropriate transplant center. The UMC transplant program may be reached through that number or 601-987-3500 (person to person, collect, for the organ procurement coordinator on call).

Cable TV Will Carry AMA's CME Programs Chicago, IL - The AMA's popular "Video Clinic" series of CME programs will soon be available to the nation's physicians on cable television. The AMA and Med-Video, a New York-based firm specializing in medical program production, will distribute the series through several major cable TV networks. Up to now the programs have been available to physicians only on videocassettes on a rental or purchase basis.

Expansion Planned At St. Dominic Hospital Jackson, MS - A \$19 million, three story Critical Care Wing is now in the planning stage at St. Dominic Hospital. The wing, designed in a cloverleaf shape with three separate pods, will be used primarily for the relocation of 40 critical care beds. Tentative plans call for moving the ICU, CCU and Special Care Unit, the ICU/CCU family waiting room, and the departments of Hospital Education and Radiology Services to the new wing.

Mexican Marijuana Supply Down by 90% University, MS - Spraying Paraquat on Cannabis fields in Mexico has cut by 90% the amount of illegal marijuana coming into the U.S. from that country, says the director of the Ole Miss marijuana project. But there has been a significant increase in the amounts produced in the U.S. and smuggled from other countries. A spraying program is being discussed with the government of Colombia, one of the largest suppliers to the U.S. illegal market.

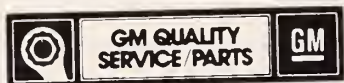
Accidents #1 Cause of Death Under Age 44 Jackson, MS - In 1982 the leading cause of death in people between the ages of one and 44 was accidents, according to Miss. State Dept. of Health statistics. In the age group 1-4, 45.9% of deaths were by accidents; age 5-14 (57.2%); age 15-24 (56.8%); age 25-44 (28.9%). After age 44 the leading cause of death was heart disease. Of accidental deaths, motor vehicles accounted for 49.9%; fires, 7.5%; falls, 7.3%; drowning, 6.1%; and firearms, 4.6%.

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PHYSICIANS . . .

*Information Kits Available
for counseling pregnant women*

Physicians, nurses and others who counsel pregnant women are now offered a "Smoking and Pregnancy" package for use in counseling about the risks of smoking during pregnancy and the health benefits of smoking cessation.

**"Because You Love Your Baby,
There Has Never Been a Better Time
to
Quit Smoking."**

According to Dr. Roland B. Robertson, Jr. of Jackson, president of the Mississippi Lung Association, the two-part program, "Because You Love Your Baby, There Has Never Been a Better Time to Quit Smoking," offers information, handbook, charts, and full color posters to health care providers for use in counseling sessions. There is also a companion package available for pregnant women which provides useful information for smoking cessation and reinforces the counselor's message.

"National statistics show that nearly half the American pregnant women do not know how smoking affects the outcome of pregnancy. It is vital that pregnant women understand the health hazards of smoking," Dr. Robertson added.

The American Lung Association created the "Smoking and Pregnancy" kits for practitioner and patient to make it possible for the busy practitioner to educate patients for "life and breath." The new program helps pregnant women understand why they should quit smoking for themselves and their babies and encourages the use of the "Freedom From Smoking" program, a self-help program for persons wanting to quit smoking.

For more information on the new "Smoking and Pregnancy" program or to order materials, contact us.

MISSISSIPPI  LUNG ASSOCIATION

P.O. Box 9865
Jackson, MS 39206

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, MS 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white paper. **Brief manuscripts (about 2,500 words or 8 pages) will be given preference over longer articles.**

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes

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In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*

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An added complication... in the treatment of bacterial bronchitis*

Increasing incidence
of ampicillin resistance in
Haemophilus influenzae

Ampicillin Resistant
Haemophilus influenzae

H. influenzae

S. pneumoniae

Brief Summary Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: General Precautions—If an allergic reaction to Cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies in transfusion cross-matching procedures when antioglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly). Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B:—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cefclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers:—Small amounts of Cefclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁵

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

hour. The effect on nursing infants is not known. Caution should be exercised when Cefclor® (cefclor, Lilly) is administered to a nursing woman.

Usage in Children:—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Cefclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis, arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain:—Transient abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic:—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic:—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal:—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Cefclor is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

- References**
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 7. Data on file, Eli Lilly and Company.
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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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ORIGINAL PAPERS

Screening for Colorectal Carcinoma in Mississippi

DAVID R. THOMAS, M.D.

Jackson, Mississippi

CARCINOMA of the colon is the second leading cause of cancer death among men and women of all ages. There has been little progress in reducing mortality in the last decade, resulting in a shift in incidence to early detection of carcinoma of the colon.¹ Most recent reviews have emphasized the late symptomatic presentation of colorectal carcinoma. DePeyster² stated that 66% of the patients he reviewed had nodal metastasis and 7-10% had hepatic metastases at the time of initial surgery. Correlating these findings with survival data, he showed survival rates of 100% and 66% for Duke's A and B lesions compared to overall national survival rates of 41%. Corman³ indicated that 45% of the patients presenting to the Lahey Clinic had Duke's C or D lesions at the time of surgery.

The goal of screening is not only to detect colorectal cancer, but to detect it at an earlier stage. Several authors have reported the results of mass screening.⁴⁻⁸ A total of 8646 individuals were screened, with 18 cancers found — a rate five times the expected case-detection rate. In those series reporting Duke's staging, 70% were either A or B, while only 30% were C or D.

The American Cancer Society has endorsed the Hemocult II method of screening for colorectal cancer. With the assistance of the Mississippi Chapter, the results of community screening in the population over 65 are reported.

A Senior Citizens Health Fair was held on the

The goal of reducing mortality from colorectal carcinoma has shifted in emphasis to early detection. The author states that the results of community screening programs indicate a need for greater physician awareness in order to implement this goal.

campus of Mississippi State University. Participation was limited to those age 65 or older. In addition to other health screening tests, participants were given Hemocult slides to be returned by mail. Three consecutive stools were sampled. Instructions were given in usage but dietary restrictions were not stressed. Samples were rehydrated and tested on arrival. Results were given by postcard if negative. Letters were sent to individuals having a positive test instructing them to see their attending physician, and the physician was also notified of the results by letter. Followup was obtained several weeks later by interview of both patients and physicians.

Slides were distributed to a total of 101 individuals. Fifty-nine returned the slides; 42 did not. Eight persons had one or more positive results for blood. Of those having positive results, 7 (88%) saw their physician. Two individuals (28%) had both a barium enema and sigmoidoscopy; the remainder had either an incomplete or no workup. Neither of the two patients evaluated had a malignancy. The study population derived from 17 communities in 15 counties.

From the Department of Medicine, University Medical Center, Jackson, MS.

The 8% rate of positive detection of stool blood compares with previously reported rates of 6.2% and 6.1%.^{6, 8} Previous studies included all patients over 40, while our participants were limited to over age 65. Compliance in returning slides (59%), compares favorably with 50% in previous community series for non-physician-examined participants.^{6, 8}

The false positive rate for Hemoccult testing is estimated to be 1-2%.⁹ The lack of specificity for human hemoglobin has led to the recommendation that a meat-free diet be implemented prior to testing. Following the reasoning of Miller and Knight,¹⁰ no specific dietary instructions were stressed although the instructional kits did contain dietary information. The theoretical advantage of a meat-free diet is obvious; however, applied to community screening one must assume that the instructions can be given clearly, that patients will comply, and that the diet will not be a deterrent to having the screening done. Appreciating that some random "diet positive" patients would be identified, it was elected to rely on re-evaluation by the attending physician.

In single-institution-study series, well over 90% of stool-positive patients are evaluated with a complete examination including barium enema and sigmoidoscopy. In community series, the followup is more dismal. Hastings⁶ reported from Mercer County, New Jersey, that 78% of patients sought followup from their attending physicians but only 36% had a complete evaluation. Richardson⁸ reported from Los Angeles that 75% of the Hemoccult positive patients sought followup and only 42% had a complete workup. Our results indicate 88% seeking

evaluation but only 28% having a complete workup.

The results of a community screening for colorectal carcinoma in an aged population show similar results to national trends in patient interest, patient compliance, and rate of positive Hemoccult stools. The efficacy of community screening programs is highly dependent on proper followup by community physicians. Greater emphasis upon physician education in colorectal cancer screening is mandatory before community screening efforts by voluntary groups are likely to have any impact on colorectal cancer mortality. ★★★

2500 North State Street (39216)

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Management of Leiomyoma

G. RODNEY MEEKS, M.D., Moderator
Jackson, Mississippi

DR. MEEKS: G.P., a 49-year-old gravida 5, para 4 black woman, complained of irregular and heavy vaginal bleeding. These symptoms had been present for 12 months and had steadily worsened. When she was first seen she had been bleeding steadily for approximately 3 weeks. Her menarche had been at age 10 and her menses had been regular until her present symptoms started. An approximately 14 weeks size tender, very irregular pelvic mass could be palpated. The adnexae could not be distinguished from this mass although clinically the mass was believed to be fibroids. The cul-de-sac was filled with a large fibroid arising from the posterior cervix. How does one evaluate this patient now?

DR. TOWNSEND: Keep in mind that the patient's perception of the amount of bleeding may vary greatly from the actual amount. Therefore, one must determine accurately how much the patient is actually bleeding. I first try to establish what is normal for her. What are her cycle lengths; how many days does she flow; how many tampons or pads does she use daily; and how soaked are these when she changes? Next I determine how the menses have changed, i.e. shorter cycles, longer duration of flow, increased number of pads, and passage of clots. Does she require more than one method of protection such as two tampons at once, tampons and pads together, or even disposable diapers? Does the woman soil her underclothes or outer clothes? Does she soil her nightgown or bed sheets? Has the increased flow caused her to limit any activities for fear of embarrassing herself socially? Finally, what is the patient's perception of the problem and how much does it affect her life style?

DR. WOOLEY: Some women bleed quite heavily yet have no difficulty controlling the flow, feel very well, and remain active. A woman with heavy men-

Panelists: Benjamin E. Box, M.D. of Meridian, Donald G. Townsend, M.D. of Hattiesburg, and O. B. Wooley, M.D. of Jackson, Mississippi

strual flow should take supplementary iron to maintain her iron reserve. If her hematocrit remains adequate, one does not need to be concerned about the bleeding. One must re-emphasize that individual women may have different perceptions about the same amount of menstrual blood. If any doubt remains concerning the amount of bleeding, a menstrual calendar may be helpful.

DR. BOX: Once I have established the fact of increased bleeding I then try to document it with laboratory studies. The first test I would order is a hemoglobin and hematocrit; however, my experience has been that unless the bleeding is extremely heavy or very prolonged these are within normal limits. A patient may not be anemic, yet the red cell indices may show microcytic hypochromic red cells because the iron stores are depleted with chronic blood loss. Iron and iron binding may document excessive blood loss even earlier. Some physicians draw a hematocrit immediately before and after menses to try to document the amount of blood loss at the time of menses. Although the laboratory data is helpful, the history remains the most reliable indicator of excessive menstrual flow.

DR. MEEKS: Her normal menstrual periods came every 30 days, lasted five days, and required five partially soaked pads on her days of heaviest flow. Now the patient often required two tampons and a pad to control the bleeding. She frequently soiled her underpants and she limited her social activities during times of heavy bleeding. She regularly soiled her bedclothes and sheets. She bled for as long as ten consecutive days. Her hematocrit was 29% at the

first office visit, and she was given iron supplements at that time. What differential diagnoses should be considered in a patient who has a pelvic mass and heavy vaginal bleeding?

DR. WOOLEY: Acronyms help me remember the causes of many elementary clinical gynecologic problems. The one for bleeding is CAFEE which represents carcinoma, abortion, fibroids, ectopic, and endocrine. The one for pelvic mass is PREMIO which represents pregnancy, retroversion of uterus, ectopic, myoma, infection, and ovary.

Carcinoma, fibroids, and infection must be considered in a 49-year-old woman with bleeding, pelvic mass, and pain. Because she is at the time of the climacteric, endocrine abnormalities are also a possibility.

DR. MEEKS: How would one make a definitive diagnosis?

DR. TOWNSEND: Although pregnancy is very unlikely, a serum pregnancy test would eliminate ectopic, incomplete abortion, and intrauterine pregnancy if it were negative. Infection can ordinarily be eliminated by a normal white blood cell count and sedimentation rate. The bleeding must be evaluated by some form of endometrial sampling, such as endometrial biopsies or dilatation and curettage (D&C).

DR. BOX: A patient in the perimenopausal age range should be evaluated by dilatation and fractional curettage. One can then examine the endometrium to rule out endometrial hyperplasia as well as cancer. The examination under anesthesia (EUA) gives one a good idea of whether or not the mass represents fibroids. Also, by sounding the uterus one may be able to separate uterine vs ovarian enlargement.

DR. MEEKS: The patient's pregnancy test was negative and the white blood count only 10,000/mm³. The uterus sounded to five inches. What additional work up would be helpful?

DR. BOX: Anyone who has a large pelvic mass should have an intravenous pyelogram (IVP) because the ureters could be obstructed or deviated. This is especially important if one is anticipating surgery.

DR. TOWNSEND: A barium enema (BE) is also warranted because inflammatory bowel disease or bowel cancer can produce a pelvic mass. In addition, a gynecologic mass may involve the rectum. A stool guaiac to test for occult blood will rule out most other serious bowel problems.

DR. WOOLEY: A sonogram would help confirm



Figure 1. Preoperative intravenous pyelogram. Mild calyectasis, slight dilatation of the ureter and extrinsic mass effect of the bladder are demonstrated.

the diagnosis. However, I am not sure that the management changes because the patient will require surgery.

DR. MEEKS: The IVP showed mild calyectasis, dilatation of the ureter, and bladder distortion by an extrinsic mass (see Figure 1). The BE was normal and a sonogram was not ordered. How does one decide which patients need surgery?

DR. BOX: At least a small amount of philosophy is involved. Many myomas may be managed by prudent observation. This is especially true of patients who have small asymptomatic myomas. The confusion of small myomas with various neoplasms is unusual and the risk of sarcomatous change in myomas which are not growing is almost nonexistent. I would discuss the situation with the patient and determine if she feels a hysterectomy would improve her situation.

DR. TOWNSEND: Abnormal bleeding, especially if it leads to anemia, is probably the most common reason for surgery. Less commonly, pressure in the

pelvis, dyspareunia, dysmenorrhea, myoma infarction, or prolapse of a fibroid through the cervix will cause pain severe enough to warrant surgery.

DR. WOOLEY: Once the uterus is larger than 12 weeks gestational size or has been displaced outside the pelvis, evaluation of the adnexae is impossible and an ovarian neoplasm may be missed. In addition, lateral myomas or pedunculated myomas may be confused with adnexal masses. One of the early features of sarcoma is rapid enlargement of a myoma, especially in the postmenopausal period. All of these situations may necessitate surgery even if there are no other symptoms.

DR. BOX: Urinary tract complaints such as urgency and frequency are commonly associated with myomas and probably result from simple compression or distortion of the bladder. Ureteral compression may occur especially if the myomas arise out of the pelvis and may lead to hydronephrosis or hydro-nephrosis. In severe cases one may even see renal failure. Certainly these are indications for surgery.

DR. MEEKS: Should this patient have surgery?

DR. WOOLEY: I feel the patient warrants surgery. She meets many of the criteria we have just outlined. Some pathologists are now willing to do frozen sections on endometrium. If one could obtain a frozen section on the D&C specimen than one would be able to proceed to exploratory laparotomy.

DR. TOWNSEND: I agree surgery is indicated.

DR. MEEKS: Would the abdominal or vaginal approach be preferred?

DR. BOX: Once the uterus is 10 to 12 weeks size (2½ times normal), the abdominal approach is better. Although some people feel the vaginal approach is warranted even if it requires morcellation of a large uterus, I feel it is often more time consuming and often leads to increased blood loss.

DR. MEEKS: The patient was taken to the operating room. The EUA revealed a 16 weeks size mass consistent with fibroids. A D&C was done and a frozen section on the curettings was reported as "benign endometrium." At the time of exploratory laparotomy the diagnosis was confirmed. Should the ovaries be preserved?

DR. WOOLEY: I would remove the ovaries in anyone past 45 years of age, because of the risk of ovarian cancer.

DR. TOWNSEND: Although classic teaching would support removal of ovaries in a woman beyond 45 years of age, I would have taken a more conservative approach. I would preserve the ovaries in any premenopausal woman if they were normal. The ovaries function beyond menopause and may have significant function into the sixth and seventh decade.

DR. BOX: The ovaries may help protect the patient against osteoporosis and genital atrophy, and I would preserve them if they appeared normal.

DR. MEEKS: The patient underwent total abdominal hysterectomy and bilateral salpingo-oophorectomy. Her postoperative course was complicated by anemia and fever thought to be from the surgical site. She responded to transfusions and antibiotics. She was discharged on postoperative day 8 on conjugated estrogen. Two weeks later she was treated for cystitis. She was doing well at the time of her six weeks postoperative visit.

In summary, approximately 20% of women by age 40 will develop uterine leiomyomas. Therefore they are one of the most important benign disease entities of women. Black women are more likely to develop leiomyomas than are caucasian women. The terms "fibroids" and "fibroid uterus" are misnomers because these growths are not fibrous but rather are smooth muscle tumors. They may develop from the uterine muscle, from the smooth muscles of the uterine arteries, or from connective tissue by metaplasia.

The majority produce minimal enlargement of the uterus, are asymptomatic, and are detected at the time of routine screening. A firm, irregular, nontender midline mass which has rounded or bosselated protrusions is commonly found during physical examination. Asymptomatic myomas can be followed prudently and indeed often need no therapy.

The onset of symptoms is often insidious. The most common symptoms are menorrhagia and metrorrhagia which may cause anemia if the blood loss is excessive. Pelvic pressure, backache, heaviness in the lower abdomen, and a sense of congestion are early symptoms. Urinary frequency and constipation may become a problem as the bladder and rectum are compressed. Growth is estrogen dependent, and they may enlarge dramatically during pregnancy.

Irregular bleeding, the most common complaint, is in turn the most common indication for surgery. This should be preceded by adequate endometrial evaluation. Other indications for definitive treatment include inability to evaluate the adnexae, urinary tract obstruction, pain, and growth following menopause. Surgical management of uterine leiomyomas may have a significant effect on ovarian preservation because many gynecologists feel the ovaries should be removed at the time of hysterectomy in women beyond age 45.

Although not often serious in themselves, the magnitude of their frequency makes them a significant health problem for women. They may mask more serious pelvic pathology or complicate the

LEIOMYOMA / Continued

management of the menopause. They constitute the most common indication for major surgery in women and because of the associated surgical morbidity and mortality they should be given careful attention.

I would like to thank the panelists for their participation in Grand Rounds. The discussion was both lively and enlightening. ★★★

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Radiologic Seminar CCXXXI: "Poor Renal Sign" or "Poor Renal-Super Scan Sign" in Bone Imaging

DOROTHY S. LIN, M.D.

Jackson, Mississippi

Case 1

A 70-YR.-OLD WHITE MALE was admitted for a long history of chronic renal failure and peptic ulcer disease. His serum calcium, alkaline phosphatase and creatinine levels all were elevated. A ^{99m}Tc -MDP bone scan (see Figures 1 and 2) revealed diffuse intense increased uptake in the calvarium and the mandible. Also seen was slight diffuse increased uptake in the bony framework relative to soft tissue background activity but not diffuse enough to be called a "super scan." However, the "poor renal sign" is present since there is no activity in the kidneys and very little activity in the urinary bladder. Skeletal radiographs showed mottled "salt and pepper" appearance of the calvarium, bony resorption of the dental lamina dura as well as in the inferior aspects of the shafts of both clavicles, and the distal end of the left clavicle — findings which were all suggestive of hyperparathyroidism. A CT scan of the abdomen demonstrated bilateral small kidneys without calcium deposition.

From the workup, primary hyperparathyroidism was diagnosed and near total parathyroidectomy was performed for two parathyroid adenomas. The cause for the "poor renal sign" in this patient is presumably on the basis of poor renal function and increased bone uptake due to primary hyperparathyroidism.

Case 2

A 53-yr.-old female presented with severe anemia and bone pain. Five years prior, she had had bilateral mastectomy performed for breast carcinoma. She had received no further treatment. On admission,

her calcium was 8.8mg/100ml, phosphorus was 3.3 mg/100ml, alkaline phosphatase was 2.5 units, levels which were all in or near the ranges of normal. Her renal function tests were normal. A ^{99m}Tc -MDP bone scan (see Figure 3) revealed a "poor renal — super scan sign" since there was homogeneous increased uptake in the skeletal system (except for L4 and L5 area) relative to soft tissue background activity, and nonvisualization of the kidneys. A ^{99m}Tc -sulfur colloid scan (not shown) demonstrated diffuse decreased bone marrow activity. Sternal marrow biopsy showed diffuse metastases from adenocarcinoma of breast.

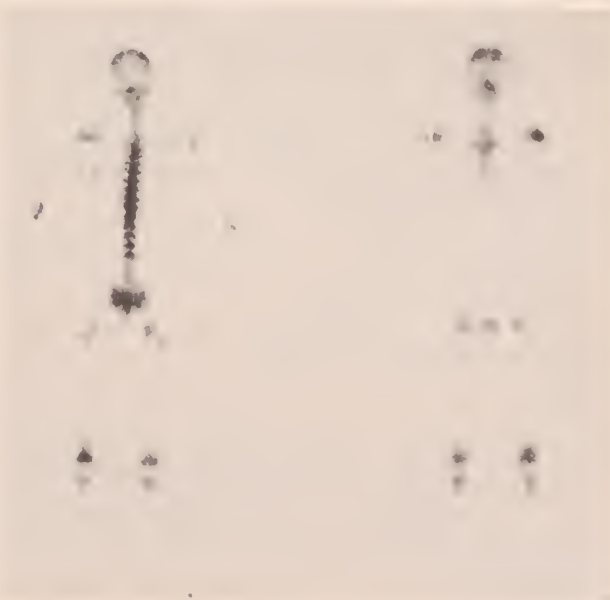


Figure 1. Anterior bone image showing diffuse intense increased uptake in the calvarium and the mandible. Very little activity is seen in the urinary bladder.

Sponsored by the Mississippi Radiological Society. From the Department of Radiology, University Medical Center, Jackson, MS.



Figure 2. Posterior bone image. In addition to the findings seen in the anterior image, there is "poor renal sign."



Figure 3. Bone image showed homogeneous increased skeletal uptake except for L4-L5, and non-visualization of kidneys and urinary bladder. It is of a "poor renal — super scan" pattern when compared to the relative decreased soft tissue background activity.

Causes of "poor renal sign" in bone imaging may be classified according to the following:

- A. Decreased renal excretion, ie, renal failure, on dialysis^{1, 2, 3}
- B. Increased bone uptake — "steal phenomenon"^{1, 2, 3, 4}
 1. diffuse "super scan" pattern^{5, 6} — metastases, metabolic disease, hematologic diseases with expanded bone marrow space causing extensive bone remodeling.
 2. focal intense increased uptake — metabolic disease, fibrous dysplasia, Paget's disease
- C. Increased soft tissue uptake, i.e., extensive cellulitis, neuroblastoma*
- D. Normal children — because of normal epiphyseal uptake and rapid renal excretion when using ^{99m}Tc-MDP⁷

Gamut For "Poor Renal Sign"

Common

Diffuse metastases — from prostate,^{1, 2} breast,^{1, 2} urinary bladder,^{1, 2} lung,^{1, 2} renal pelvis,⁴ colon,* melanoma,* rhabdomyosarcoma,* embryonal cells,* etc.

Renal failure¹

Paget's disease¹

Secondary hyperparathyroidism^{1, 2, 3}

* Based on personal experience.

Renal osteodystrophy²

Normal children⁷

Uncommon

Primary hyperparathyroidism²

Polyostotic fibrous dysplasia²

Lymphoma^{1, 2}

Leukemia²

Aplastic anemia²

Myelofibrosis^{2, 8}

Osteomalacia or rickets²

Neuroblastoma*

Extensive cellulitis*

Rare

Hypervitaminosis D²

Waldenström's macroglobulinemia²

Systemic mastocytosis²

Hyperthyroidism⁹

Diffuse skeletal hemangiomatosis⁶

Gamut for "Poor Renal — Super Scan Sign"

Common

Diffuse metastases — from prostate,³ breast,³ lung,³ urinary bladder,³ lymphoma,^{3, 5} renal pelvis,⁴ and rhabdomyosarcoma*

Secondary hyperparathyroidism³

Renal osteodystrophy²

Paget's disease³

Uncommon

Primary hyperparathyroidism³

Osteomalacia or rickets²

Acute myelocytic leukemia²

Myelofibrosis³

Aplastic anemia²

Rare

Hypervitaminosis D²

Systemic mastocytosis³

Waldenström's macroglobulinemia²

Hyperthyroidism⁹

Diffuse skeletal hemangiomatosis⁶

★★★

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The President Speaking

A Paradox

Whitman B. Johnson, Jr., M.D.
Clarksdale, Mississippi

One of the hardest things in life to do is to express one's thoughts so that they can be understood as they are intended. It has been said, "No one ever agrees with anyone else, only his opinions expressed by someone else." So it is with ambivalence that I write these ideas on a paradox that we all face constantly and which affects our public image, external pressure, family lives, personalities, and actions. This paradox involves altruism and egoism; egoism meaning self-interest, and altruism, interest in others without regard of self. Nowhere else in life is this paradox balanced on a razor's edge as it is in the medical profession.

The more egoistic a businessman can be, the more he is esteemed, as long as he doesn't break the law. A clergyman, on the other hand, is supposed to be completely altruistic and dependent on the generosity of others. The lawyer is involved in a paradox weighed in favor of self-interest in that no matter what he does and says, or who he injures, or whether justice is carried out he is appreciated as long as he wins his case and confidentiality is maintained.

Medicine is a skill that must be learned at high cost of money and time, but must be applied frequently to those who are at least temporarily infirm, disabled, and often poor. Certainly, everyone who has developed these skills deserves to be paid adequately for his services. The medical license was developed not only to insure the quality of care and to protect the practitioner and public from quackery, but also to guarantee access of all the public to this care. It allows the licensed physician to practice the art (altruism) and science (egoism) of medicine. Without practicing both, can one truly call himself a physician?

The ancient Greeks practiced their skills with little thought of anything but making a good living; but in the Middle Ages, the Knights Templar was founded to treat the sick on the Crusades as "their lords." They were obliged to treat plague victims without pay, and many died doing so. There are also parallel traditions in Jewish medicine.

With the development of increased competition and advertising, with the formation of new types of practice such as "for profit" completely egoistic clinical corporations that don't offer care 24 hours a day or don't treat people unable to pay, and with the effect of "DRGs," "PPOs," "HMOs," "IPAs," and prepayment of care, where the patient might be sent to the lowest bidder without regard to quality, there will be increased temptations to become more self-interested and less altruistic. Those who succumb to these temptations and fail to practice both the art and science of medicine will become technicians and should lose the right to call themselves physicians. Let us not forget our Judeo-Christian medical heritage and thus find ourselves acting like ancient Greeks. ★★★

So Much for the Loyal Opposition

It was a hot day in May, nineteen hundred and eighty three
A number of us Mississippi Doctors had gathered by the Sea.
It was the annual meeting of the M.F.M.C.
This was the culmination of the feud, you see.
Dr. Weems for the "loyal ones" arose
and expounded in very eloquent prose
With head reverently bowed, I listened with great intent
Of how wonderful P.R.O. was and to what extent.

I was called the "loyal opposition" that day
And asked, as such, if I had something to say.
With dry mouth, heart thumping, and short of breath,
I stood with thoughts of "yea, though I walk through the
valley of death"

I talked of how I hoped my patients' health care was the best
And how we all hoped to pass the P.R.O. test.
Of how the M.F.M.C. stirred my Ire,
And that a closer communication was my utmost desire.
Of how bad I felt the Feds had treated us
And how I felt that we should continue to fuss.
Of how you give the Feds an inch
And they pull the strings tighter and make them pinch.
Of how, we need to get the bad apples out
For that's what this P.R.O. is all about.

I firmly believe that a voluntary review
Would get us out of this stew.
Surely the changes that have been made are good
And now that we're better understood
Let the "loyal opposition" and the others
Work together like dedicated brothers.
The changes in Mississippi medicine are coming fast
So let's all get in there and work so we won't be surpassed.
For when all's been said and done
The patients are the ones who will have really won.

JOSEPH E. JOHNSTON, M.D.
Associate Editor

Roche salutes
the history of Mississippi medicine



SOLVING THE MYSTERY OF PASCAGOULA

More than 20 years ago, a combined demonstration of medical science and community effort turned an outbreak of infectious hepatitis in Mississippi into a national landmark of disease prevention.¹

When health officials in Pascagoula, Mississippi, reported more than a dozen cases of hepatitis, the Communicable Disease Center in Atlanta assigned an epidemiologist to aid local efforts in tracing the origin of the infection.

Nurses on duty at the Jackson County Health Clinic and physicians at Singing River Hospital were interviewed, as were the patients themselves. It soon became clear that the patients had not shared a meal, had not frequented the same restaurant and had not been together in any of the most likely sites for contamination. However, a startling fact did come to light... each of the 13 infected patients had eaten raw oysters within the previous two months.

Checking and double-checking the clues...

Raw oysters were a common food in Pascagoula, but at that time shellfish were not known to cause hepatitis. As a control, 13 names were selected from the city's

telephone book. Each person questioned denied having eaten oysters, and none had symptoms of hepatitis. The investigation was narrowing down, but there was still much probing to be done.

...to find the cause

With the assistance of a sanitation engineer and a shellfish expert, the investigators began the tedious task of inspecting the local stores, oyster plants, packagers and shucking companies. Finally, they found the source of the infections: an oyster bed at the mouth of the Pascagoula River, ordered closed to oystering some 30 years earlier because it was polluted.

The diligent work of 20 specialists—epidemiologists, virologists, bacteriologists, internists, pediatricians and public health officers—had led to an awareness of shellfish as potential hepatitis carriers, and to the need for closely regulating both shellfishing and water pollution protections. The work done in Pascagoula stands as a remarkable joint effort in the history of modern medicine in the United States.

Reference: 1. An era of specialists, chap. 5, in Lee RV, Eimerl S *et al*. *The Physician*. New York, Life Science Library, Time Inc., 1967, pp 107-109



When the history reveals anxious depression...

For the estimated 70 percent of nonpsychotic depressed patients who are also anxious,¹ Limbitrol provides both amitriptyline, specific for symptoms of depression, and the effects of Librium® (chlordiazepoxide HCl), the tested and dependable anxiolytic. Limbitrol is, therefore, a better choice for these patients than dual agents that contain a phenothiazine, a class of antipsychotic drugs used infrequently in nonpsychotic patients.¹

62% of Overall Improvement...Within the First Week

Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.²

In another multicenter study,³ the following symptoms associated with anxious depression were significantly reduced during the first two weeks of therapy:

- ☐ Headache—79%
- ☐ Early insomnia—91%
- Middle insomnia—87%
- Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.³

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

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In moderate depression and anxiety

Limbitrol®

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Please see summary of product information on following page.

LIMBITROL® TABLETS® Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief at moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those at barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias at the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation at urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema at face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100; Prescription Paks of 50.

PERSONALS

JAMES ACHORD of UMC attended recent meetings of the executive committee and board of trustees of the American College of Gastroenterology in Chicago.

ORLANDO ANDY of UMC participated in the program for a recent meeting of the American Paralysis Association in Chestnut Hill, Massachusetts.

G. WILLIAM BATES of UMC lectured during grand rounds at Tulane Medical Center in New Orleans.

BLAIR BATSON of UMC attended a government affairs committee meeting of the American Academy of Pediatrics in Washington, DC.

JOHN F. BUSEY of Jackson has been elected honorary member of the Mississippi Lung Association board of directors.

GEORGE R. BUSH of Laurel has been recertified by the American Academy of Family Physicians.

MARC A. CHETTA announces the association of CHRISTOPHER V. MATTHEWS for the practice of family medicine and obstetrics and the opening of their new office at 302 Highway 11 South in Poplarville.

WALLACE CONERLY of UMC spoke at the medical staff meeting of the Oxford-Lafayette County Hospital in Oxford.

ROBERT CURRIER was guest speaker for Neurosciences Day at the University of Tennessee Medical Center in Memphis.

C. RALPH DANIEL, III, of Jackson recently presented lectures to a continuing medical education symposium at the University of Alabama in Birmingham and to the department of dermatology at New York University.

JOHN M. FORD of Baldwin received the Doctor of the Year Award at North Mississippi Medical Center's Employee Recognition banquet.

CLAUDE EARL FOX of Jackson attended the board meeting of the Alan Guttmacher Institute in New York and also served as a member of the review panel for maternal and child health grants in Washington, DC.

JAMES HARDY of UMC was the invited lecturer at the combined meeting of the Detroit Surgical Association and the Academy of Surgery of Detroit and also



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met with vascular surgeons and resident physicians at William Beaumont Hospital in Royal Oak, Michigan.

JOHN F. HASSELL of Laurel has been recertified by the American Academy of Family Physicians.

WALTER R. HOLLADAY of Meridian recently was the subject of the "People Who Make a Difference" feature of *The Meridian Star*.

HERBERT LANGFORD of UMC attended an executive committee meeting of the Hypertension Prevention Trial in St. Louis, Missouri.

JOSEPH R. LEE of Bay St. Louis announces the relocation of his office for the practice of general surgery to 252-B Highway 90 East.

RICHARD MILLER of UMC lectured at a recent meeting of the Minneapolis Surgical Society.

SHANTI PANDEY of Fayette has been recertified by the American Academy of Family Physicians.

ANDREW PARENT of UMC presented a paper at the annual meeting of the Mississippi Neurosurgical Society in Biloxi.

ROLAND B. ROBERTSON, JR. of Jackson has been elected to serve a second term as president of the Mississippi Lung Association board of directors.

PHILLIP C. ROWDEN announces the opening of his practice in adult, adolescent and child psychiatry at 49 Sgt. Prentiss Drive in Natchez.

V. DAVID SAVELL, JR. has associated with WILLIAM G. RILEY, JOHN D. McEACHIN, and WILLIAM B. SIMMONS of Meridian for the practice of neonatal, pediatric, and adolescent medicine.

ROBERT SMITH of UMC participated on the program of the annual meeting of the Mississippi Neurosurgical Society in Biloxi.

W. LAMAR WEEMS of UMC was speaker at the Prairie Medical Society in Columbus in June.

W. BOYCE WHITE of Laurel has been recertified by the American Academy of Family Physicians.



Awake with allergies

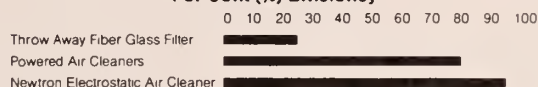


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Until now, there has not been an effective and economical method to remove these pollutants from the air. Disposable air filters are quite inexpensive... but ineffective. Powered electronic and pleated paper air cleaners are more effective... but very expensive. But now there is an air cleaner that cleans better than any other competitive air cleaner on the market regardless of cost... and we cost less.

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NEW MEMBERS

HICKS, JENNIFER O., Vicksburg. Born Vicksburg, MS, Aug. 11, 1950; M.D., Meharry Medical College, Nashville, TN, 1978; interned Homer G. Phillips Hospital, St. Louis, MO, one year; ob-gyn residency, Starkloff Hospital, St. Louis, MO, 1979-80; ob-gyn residency, Erlanger Hospital, Chattanooga, TN, 1980-82; elected by West Mississippi Medical Society.

HOWARD, A. ARCHIE, JR., Morton. Born Carthage, MS, Feb. 13, 1953; M.D., University of Mississippi School of Medicine, Jackson, 1979; family practice residency, University Medical Center, Jackson, 1979-82; elected by Central Medical Society.

JOHNSON, JOHN FRANK, Pascagoula. Born Fairhope, AL, Nov. 15, 1950; M.D., University of Alabama School of Medicine, Birmingham, 1978; interned and radiology residency, University of South Alabama, 1978-82; elected by Singing River Medical Society.

NUNNEMANN, RUDOLF, Corinth. Born Germany, Sept. 16, 1941; M.D., Ince University of Berlin, 1970; interned Germany, one year; surgery residency, Honolulu, Hawaii and Berlin 1972-74; urology residency, Mayo Clinic, Rochester, MN, 1975-78; elected by Northeast Mississippi Medical Society.

QUINIF, NICHOLAS J., Greenville. Born Toledo, OH, April 15, 1953; M.D., Medical College of Georgia, Augusta, 1978; interned, same, one year; urology residency, Northeastern Ohio University, Akron, 1979-83; elected by Delta Medical Society.

WEILAND, GERI LEE, Vicksburg. Born Camden, N.J., Nov. 21, 1955; M.D., University of Mississippi School of Medicine, Jackson, 1980; pediatric residency, University Medical Center, Jackson, 1980-83; elected by West Mississippi Medical Society.

DEATHS

COOK, H. GRADY, Hattiesburg. Born Hattiesburg, MS, Dec. 26, 1902; M.D., Tulane University School of Medicine, New Orleans, 1929; interned Touro Infirmary, New Orleans, LA, one year; died May 10, 1983, age 80.

SLAUGHTER, WILLIAM J., Meridian. Born Meridian, MS, Oct. 13, 1907; M.D., University of Tennessee School of Medicine, Memphis, 1937; interned Norfolk General Hospital, Norfolk, VA, one year; died May 29, 1983, age 75.

WILSON, DAVID T., Louisville. Born Louisville, MS, April 4, 1915; M.D., University of Tennessee School of Medicine, Memphis, 1940; died May 8, 1983, age 68.

Medico-Legal Brief

Hospital Not Liable For Failure to Supervise M.D.

A hospital was not liable for failing to supervise an attending physician in the diagnosis and treatment of a patient, the Mississippi Supreme Court ruled.

The patient was admitted to the hospital on March 4, 1974. He was nauseated, vomiting, and suffered from shortness of breath. The physician's treatment consisted of antibiotics, X-rays, and other drugs. He remained in the hospital for three days, when he was transferred to a second hospital at the insistence of his mother.

The second physician diagnosed his condition as a ruptured appendix requiring immediate surgery. The patient suffered a cardiac arrest while in surgery and died. In her complaint against the first hospital and the first physician, the patient's mother alleged that the physician was negligent in diagnosing and treating her son and that the hospital failed to properly select, train, and supervise the physician.

On appeal from an adverse decision by the trial court, the patient's mother argued that the hospital was liable for negligence in failing to supervise the physician's diagnosis and treatment. The Supreme Court observed that only an individual physician could practice medicine. There was no allegation that hospital employees were negligent in treating the patient, the court said. If the hospital had a duty to second guess a physician's diagnosis and treatment, it would be illegally practicing medicine, the court said. It would not impose that duty.

The trial court's decision was affirmed. — *Porter v. Pandey*, 423 So.2d 126 (Miss.Sup.Ct., Dec. 8, 1982)

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MEDICAL ORGANIZATION

Reagan Addresses AMA Delegates

(Editor's Note: The following story is reprinted from the "AMA Legislative Roundup," June 24, 1983.)

In a speech before the AMA House of Delegates last Thursday, President Ronald Reagan declared that "it's high time we put health care costs under the knife and cut away the waste and inefficiency. The growth in medical costs is malignant and must be removed for the continued health of the American people." The speech lasted about 25 minutes and was warmly received by the delegates, who interrupted his presentation 18 times with applause.

Reagan stated that his administration in 1984 "will devote more money to health care than any administration in history." To restrain health costs, he outlined the administration's health incentives reform package which was included in the HHS budget submitted earlier this year. These reforms are the Medicare prospective payment system (already enacted), the proposed increasing of Medicare patient cost-sharing in the early parts of a hospital stay combined with catastrophic coverage for longer stays, and capping the amount of health insurance benefits received tax free.

The President also alluded to other proposed administration reforms that he realized that the AMA does not support, including Medicare vouchers and competitive bidding and the one-year freeze on Medicare physician reimbursement. With regard to this last, Reagan stated that "we believe physicians, too, must share the burden of slowing the rise in health care costs. As the patient in the movies often says, 'Give it to me straight, Doc.' Well, we believe the straight answer is that a one-year freeze is painful but necessary medicine."

Reagan received perhaps the loudest applause in his speech when he departed slightly from his prepared text to declare that the United States has the best health care in the world because it has been a private system, as opposed to a governmentally-controlled one.

Continuing the promotion-of-education theme of recent speeches, the President referred to medical technology advances such as "computers, lasers, nuclear devices and various Star Wars technologies" and stated that this trend should be continued

by "promoting solid math and science skills in our schools."

President Reagan congratulated the AMA for its cost-effectiveness programs and initiation of the Health Policy Agenda for the American People. He ended his speech with a reference to his administration's efforts at arms control and drew strong applause when he stated that "nuclear war cannot be won and must never be fought."

Southeastern HBP Conference Scheduled in Biloxi

Mississippi physicians can consider both sides of the controversy and also examine new approaches to the management of high blood pressure at the Ninth Annual Southeastern High Blood Pressure Conference October 5, 6, and 7 at Biloxi.

Physicians, nurses, pharmacists, dietitians, and others involved in hypertension management throughout the Southeast will participate in the event at the Royal d'Iberville Hotel.

Marvin Moser, M.D., will deliver the keynote address, "Hypertension and Cardiovascular Diseases," on the opening day. Dr. Moser is senior medical consultant to the National Heart, Lung, and Blood Institute's National High Blood Pressure Education Program and clinical professor of medicine at New York Medical College.

Other conference topics include the role of nutritional approaches and the relationship of calcium intake to hypertension treatment; high blood pressure in the young person; patient education; and antihypertensive agent interactions with other drugs.

In seminar session, participants will discuss controversies in the treatment of mild hypertension, including conflicting data from the Hypertension Detection and Follow-up Program (HDFP) and Multiple Risk Factor Intervention Trial (MRFIT); representatives of both HDFP and MRFIT will participate.

Concurrent abstract sessions are planned for the second day.

Conference sponsors include the Mississippi State Department of Health, American Heart Association

HYPERTENSION CONFERENCE / Continued

— Mississippi Affiliate, Kidney Foundation of Mississippi, Mississippi Nurses Association, and National High Blood Pressure Education Program.

Application has been entered to provide continuing medical education credit through the University of Mississippi Medical Center.

Early registration with name, address, Social Security and telephone numbers may be mailed to High Blood Pressure Conference, State Department of Health, P. O. Box 1700, Jackson, MS 39205. Checks for \$35 registration fee should be made payable to Southeastern HBP Conference.

Additional information is available by contacting the Hypertension Program at the State Department of Health, telephone 961-4088.

UMC Will Host Conference on Diabetes

The University of Mississippi Medical Center will host a conference for physicians on diabetes and other endocrine and metabolic disorders October 6-7

at the Holiday Inn Medical Center in Jackson.

The program will present new findings about the disorders and advances in diagnostic tests and therapy.

Sponsors of the course are the UMC departments of medicine, family medicine, neurosurgery, obstetrics-gynecology, pediatrics and surgery and the UMC Division of Continuing Health Professional Education.

Course coordinator is Dr. Herbert G. Langford, professor of medicine and director of the Clinical Research Center. Joining faculty members from UMC is featured speaker Dr. Harold E. Lebovitz, professor of medicine and chief of endocrinology and metabolism/diabetes at the Downstate Medical Center at the State University of New York in Brooklyn.

The American Medical Association will award 11.33 contact hours in Category I of the Physician's Recognition Award and the American Academy of Family Practitioners 11.33 contact hours. Continuing education credit of 1.1 will also be awarded.

For more information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

Explore Controversies and New Approaches to the Management of High Blood Pressure



To pre-register or for more information, contact

Hypertension Program
Mississippi State Department of Health
P. O. Box 1700
Jackson, Mississippi 39205
Telephone 601/961-4088

ninth southeastern
**HIGH BLOOD PRESSURE
CONFERENCE** **October 5-7, 1983**

Hand Problems, Fracture Bracing Are CME Course Topics

The University of Mississippi Medical Center will present a course on immobility problems of the hand and splinting and fracture bracing September 8-9 at the Holiday Inn Medical Center in Jackson.

The first day of the workshop covers problems resulting from hand immobility, including edema and pain; a review of hand anatomy and physiology; and demonstrations of therapeutic approaches. The second day features lecture and clinical sessions on new compression techniques for fracture braces of the arm; splinting sports injuries; and lower extremity splinting. Registrants may elect to attend one or both days.

Sponsors of the workshop are the UMC School of Medicine departments of surgery (Division of Orthopedics) and family medicine, the UMC School of Health Related Professions departments of physical and occupational therapy, University Hospital departments of physical and occupational therapy and the UMC Division of Continuing Health Professional Education. Course coordinators are Mary Adams, E.Ed., O.T.R., assistant professor and director of occupational therapy, and Neva Greenwald, M.S.P.H., R.P.T., associate professor and chairman of physical therapy.

UMC faculty include Dr. Alan E. Freeland, associate professor of surgery (orthopedics); Dr. James L. Hughes, professor of surgery (orthopedics) and chief of the Division of Orthopedics; Dr. Barry W. Sauer, associate professor of surgery (orthopedics); Dr. Ellie T. Sturgis, assistant professor of psychiatry and human behavior (psychology); and Dr. James Michael Weaver, resident in surgery (orthopedics).

Course fee is \$100 for both sessions, or \$65 for one session. Credit of 5.2 hours for the first day and 7 hours for the second day will be awarded by the American Academy of Family Physicians and the American Medical Association in Category I of the Physician's Recognition Award.

For more information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601) 987-4914.

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

Orthopedics Symposium Presented at UMC



A symposium on the Ender nailing techniques was presented at the University of Mississippi Medical Center in Jackson in June. Dr. Hans G. Ender (second right), guest lecturer and developer of the techniques, is attending surgeon at the Lorenz Bohler Accident Hospital in Vienna, Austria. The program was sponsored by the UMC School of Medicine Department of Surgery Division of Orthopedics. Pictured, left to right, are UMC faculty members Dr. Alan Freeland, associate professor of surgery (orthopedics); Dr. E. Frazier Ward, associate professor of surgery (orthopedics); and Dr. James L. Hughes, professor of surgery and chief of the division of orthopedics.

Medical Center Announces Faculty Promotions

Three faculty members moved up to the rank of professor in centerwide and School of Medicine promotions announced at the University of Mississippi Medical Center in Jackson this month.

Dr. Norman C. Nelson, UMC vice chancellor, announced the changes in faculty status following approval by the Board of Trustees, State Institutions of Higher Learning.

Dr. John P. Kapp, neurosurgery, was promoted to professor in the School of Medicine. Centerwide faculty moving up to the rank of professor were Dr. Mark O. J. Olson, biochemistry, and Dr. Roy Davis Manning, Jr., physiology and biophysics.

Dr. Kapp earned the B.S., M.D. and Ph.D. degrees at Duke University and took his residency in neurosurgery there as well. On staff at UMC since 1980, he was also assistant professor of neurosurgery at the University of Tennessee. Dr. Kapp

has been an attending neurosurgeon at several hospitals in Jackson, Panama City and Memphis. He served as a neurosurgical consultant for the United States Army in Vietnam.

On staff at UMC since 1979, Dr. Olson was an associate professor of pharmacology at Baylor College of Medicine in Houston. There he was an investigator in the Nuclear Phosphoprotein Project of Cancer Program Project Grant. He was also a visiting scientist in the Laboratory of Nutrition and Endocrinology at the National Institutes of Health in Bethesda, Maryland. Dr. Olson earned the Ph.D. degree at the University of Minnesota and the B.A. at St. Olaf College.

A native of Jackson, Dr. Manning has been on staff at UMC for 10 years. He is also an alumnus of Ole Miss, where he received the B.S. and M.S. in chemical engineering and the Ph.D. in biomedical engineering. Dr. Manning has also been with the Exxon Corporation in engineering design and research. Among his research interests are hypertension and cardiovascular physiology.

School of Medicine faculty promoted to the rank of associate professor were Dr. Junius G. Adams III, preventive medicine; Dr. John M. Boyce, medicine; Dr. Jack Rubin, medicine; Dr. Kent M. Kirchner, medicine; Dr. James L. Parker, neurology; Dr. Donald Prue, psychiatry and human behavior; Dr. Anupam Routh, radiology; Dr. Philip E. Cranston, radiology; and Dr. E. Frazier Ward, surgery. Among centerwide faculty, Dr. Steven T. Case, biochemistry, also was named to the rank of associate professor.

School of Medicine faculty moving up to the rank of assistant professor were Dr. Venkateshiah Sathyanarayana, clinical laboratory sciences; Dr. Cyril D'Cruz, pathology; Dr. Nancy Hobson, pediatrics; and Dr. Reda A. Scott and Dr. Martha Murray, both in psychiatry and human behavior.

RECOLLECTIONS

Ten years ago the August 1973 issue of JOURNAL MSMA reported on the annual meeting of the Mississippi Academy of Family Physicians. Dr. William Bernard Hunt of Grenada was inaugurated pres-

ident of the Academy, succeeding Dr. Eugene F. Webb of Itta Bena. Other officers were: Dr. Thomas J. Anderson of Laurel, president-elect; Dr. Richard T. Furr of Ocean Springs, vice-president; and Dr. Marion L. Sigrest of Yazoo City, secretary-treasurer.

A news story announced that six Mississippi physicians were named fellows of the American College of Physicians. They were Dr. Kenneth R. Bennett, Dr. John D. Bower, Dr. Bernard J. Dreiling, Dr. William R. Lockwood, Dr. William M. McKell, Jr., and Dr. Robert E. Tyson, all of Jackson.

That same issue of the JOURNAL included an article recognizing Dr. John Longest, who had received a distinguished service award from the Mississippi State University Alumni Association. At that time Dr. Longest was in his 25th year as director of the Student Health Center at MSU.

The MSMA Auxiliary was celebrating its 50th anniversary during 1973. An article by the president, Mrs. W. H. Preston, summarized the auxiliary's history and outlined plans and projects during the organization's golden anniversary year.

Scientific articles included: "Pulmonary Embolism — An Unsolved Problem," by Dr. Donald A. Hopkins of Jackson; "Case Report XV of Maternal Mortality Study," by Dr. K. Ramsay O'Neal of Hattiesburg; and "Radiologic Seminar CXXX: Foreign Bodies in the Esophagus," by Dr. Nadia Tyson of Jackson.

The August 1963 issue of JOURNAL MSMA published "The Fedicare Folly," an address by George M. Fister, M.D., of Ogden, Utah, president of the AMA. Dr. Fister's address was delivered before the MSMA House of Delegates during the association's 94th Annual Session. Commenting on the King-Anderson legislation before the Congress that year, Dr. Fister noted that the basic issue was not health care for the aged versus no health care, but rather, how the care should be provided. Dr. Fister declared, "It is the AMA that is leading the fight to preserve the private practice of medicine, the freedoms of patients, and free enterprise system in this country by opposing vigorously political schemes to place the control and domination of a great profession and the patients in the hands of the federal government."

Other items in the JOURNAL twenty years ago included news of the adoption of the interprofessional code between MSMA and the Mississippi Bar Association and a report on groundbreaking ceremonies for the new 221-bed Hinds General Hospital in Jackson.

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PATHOLOGIST seeks location in Mississippi. M.D., Ohio State University; residency, University of Alabama. Contact Janice Blazina, M.D., 2323 DeLee St., Apt. 31, Bryan, TX 77801.

NOTICE

INTERNS, RESIDENTS, ANY PHYSICIAN LICENSED TO PRACTICE MEDICINE IN MISSISSIPPI

Positions for part-time medical consultants are now available at the Disability Determination Services of Mississippi. The pay and hours are good. Interns and residents wanting to interrupt their training programs for a year or more are welcome to apply. If interested, call 922-6811, ext. 2277 (Dr. John Barr) or ext. 2000 (Mr. John Cook).

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FAMILY PRACTITIONER, surgeon and ob-gyn to locate with established practice in south Mississippi. Salary negotiable, partnership arrangement. Write Box A-115, Journal MSMA, P.O. Box 5229, Jackson, MS 39216.

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PHYSICIAN ASSISTANT, '83 Stony Brook, NY. Board eligible. Excellent references. Seeks primary care or ER position within 60-mile radius of Jackson. Priscilla Virant, 6646 Old Canton Rd., Apt. #53, Jackson, MS 39211.

Next Month in JOURNAL MSMA

"The Increasing Supply of Physicians, the Changing Structure of the Health-Services System, and the Future Practice of Medicine"

Alvin R. Tarlov, M.D., Chicago, IL

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IN CONCLUSION

The National Committee for Prevention of Child Abuse (NCPCA) has just completed a 3½ year evaluation of eleven different child abuse prevention strategies around the country. Reports available include: "What Have We Learned About Preventing Child Abuse," "Perinatal Intervention," "Culture-Based Parent Education Programs," "Public Awareness and Education Using the Creative Arts," and "Community-Wide Education Information and Referral Programs." For ordering information contact NCPCA, 332 S. Michigan Ave., Suite 1250, Chicago IL 60604.

Serialization rights to all five American Medical Association consumer books were purchased by the Los Angeles Times newspaper syndicate. Some 1,500 newspapers in the United States and Canada that subscribe to the syndicate will have the option of publishing the AMA material. Titles covered in the arrangement are "The AMA Handbook of First Aid and Emergency Care," "The AMA Book of HeartCare," "The AMA Book of WomanCare," "The AMA Book of BackCare," and "The AMA Family Medical Guide."

Medroxyprogesterone acetate (Depo-Provera) has not been found to be harmful, according to reports in the June 3 issue of JAMA. After granting approval in 1973 for use in the U.S., the FDA reversed its decision in 1978, noting increased incidence of mammary cancers in animals and menstrual irregularities in women exposed to the drug, which is used by approximately 1.5 million women worldwide. At the end of a 13-year study involving 5,000 women, however, researchers at the CDC concluded the drug is safe with continued monitoring.

Physicians' fees increased by 0.3% in May, according to the consumer price index. On an annualized basis, it was the smallest increase in more than five years. The increase was less than the increase in the all-services component of the CPI (up 0.4%) and the all-items index (up 0.5%). During the past 12 months the physicians' services index has risen by 7.8%. The medical care services index rose 9.5% and the overall medical care index was up 9.4%. The hospital room charge index was up 12.1% in the same period.

Toxic shock syndrome (TSS) can affect men as well as women, causing life-threatening infections after surgery, say investigators in an article in the July issue of Archives of Surgery. They report three cases and postulate that toxic shock occurs when staphylococcal bacteria enter the body through traumatized tissue sites. They conclude that TSS represents a potential complication in the postoperative setting that is being recognized with increasing frequency and can transform a routine procedure into a life-threatening one.

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- Contraindicated in patients who are pregnant or hypersensitive to flurazepam.
- Caution patients about drinking alcohol, driving or operating hazardous machinery during therapy.



References: 1. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 4. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 5. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Kales JD: *Pharmacol Physicians* 4:1-6, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5:25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The

sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

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September 1983

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September 1983, Volume XXIV, Number 9

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INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS **PREGNANCY:** VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets. VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

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NEWSLETTER

September 1983

Dear Doctor:

The MSMA's annual session has seen a number of changes in recent years, due to actions taken by the House of Delegates toward reorganizing and improving the five-day meeting. And next year's annual session (May 16-20, 1984) will again see some changes. At the recent annual meeting of the Council on Scientific Assembly, plans for the scientific portion of the meeting were developed. Replacing 15 separate (and oftentimes concurrent) specialty section meetings will be two half-day plenary sessions developed by a surgery planning group and a medicine planning group.


Seven of MSMA's scientific sections (surgery, EENT, ob-gyn, pathology, orthopedic surgery, urology, and anesthesiology) have joined resources to plan the surgery plenary session (Friday morning, May 18). The remaining eight scientific sections (medicine, family practice, radiology, pediatrics, psychiatry, preventive medicine, dermatology, and emergency medicine) have responsibility for planning the medicine plenary session, set for Saturday morning, May 19.

State specialty societies will again be invited to hold business and/or scientific meetings during MSMA's annual session, as long as they do not conflict with the plenary sessions. Complete details of the program will be announced at a later date, but MSMA members are urged to mark their calendars now for the 116th Annual Session in Biloxi.

Another important date on the MSMA calendar is March 3-4, when the association's annual health issues seminar will be held in Jackson. Topics for discussion will include hospital/medical staff relations, DRG reimbursement under Medicare, competition between hospitals and physicians, and hospital staff privileges. One address from this year's seminar -- Dr. Alvin Tarlov's report on the future of the practice of medicine -- is printed in this issue of Journal MSMA.

MSMA continues to support the AMA's Patient Medication Instruction (PMI) program. According to a recent survey of physicians who have used PMIs, 86% were satisfied with the instruction sheets, and almost 50% believed that PMIs will decrease their risk of malpractice claims. The survey also found that 70% of physicians believe PMIs increase patient compliance and increase patient satisfaction with the visit.

Sincerely,



Patsy Silver
Managing Editor

MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 17-21, 1984, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

Mississippi State Medical Association, 116th Annual Session, May 16-20, 1984, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 13-17, 1984, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39221.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November, H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clark, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Richard C. Carter, Pres. and Secy., 314 W. Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. S. B. Fineberg, Sec'y., 2204 Old Mobile Hwy., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Pendergrass, Secy., 201 Hospital Dr., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

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316 Medical Arts Building
Jackson, MS 39201

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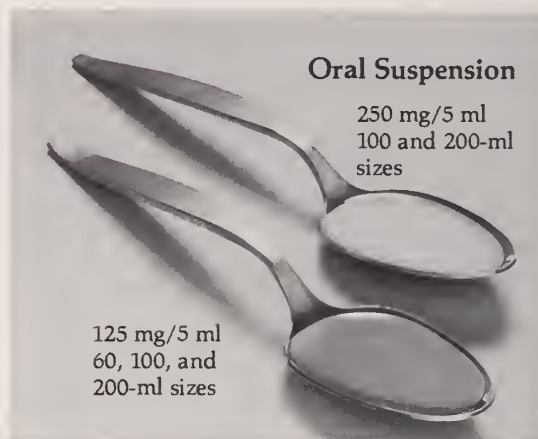
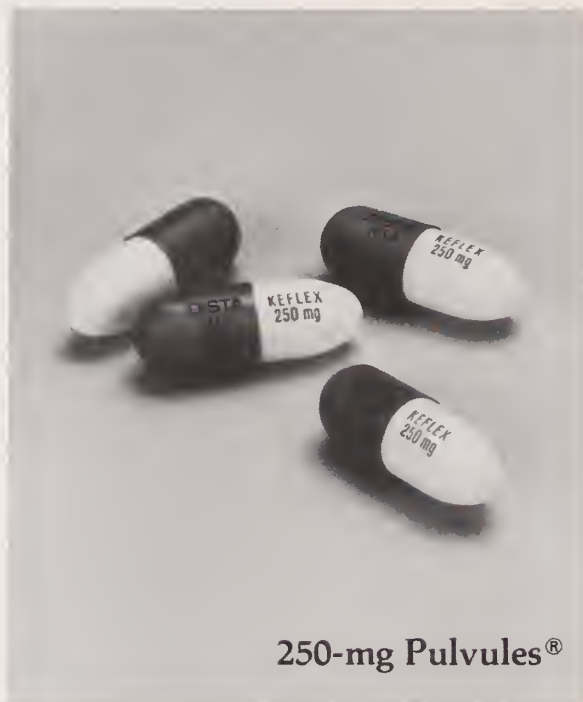
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DATELINE

MD Recruitment Reception Planned

Jackson, MS - The Department of Family Medicine, University Medical Center, will sponsor a reception for physician recruitment on October 20 at the Sheraton Regency Convention Center in Jackson. The purpose will be to introduce available residents to physicians, mayors, hospital representatives, and other parties interested in recruiting physicians for their communities. Contact the UMC Dept. of Family Medicine for information.

Oncology Symposium In Jackson

Jackson, MS - The University Medical Center and the American Cancer Society, Mississippi Division, are co-sponsoring a symposium on cancer of the chest. The Oncology Symposium No. 7, scheduled for September 22 at the Holiday Inn Downtown, will cover all aspects of lung cancer, mesothelioma, and lung metastases. Also, the results of treatment of lung cancer by practicing oncologists in Mississippi will be presented.

SBH Addresses Asbestos Control

Jackson, MS - At its July 1983 meeting the Mississippi State Board of Health endorsed recommendations on asbestos control and removal. The Board recommends establishing a statewide asbestos control and removal program as part of the State Building Commission with funding from the legislature. Under the proposal, State Health Department staff would be available to assist in setting priorities and in assisting with samples analyses.

AIDS Added to List of Reportable Diseases

Jackson, MS - The Mississippi State Board of Health took action in July to include acquired immune deficiency syndrome (AIDS) as a Class 2 Reportable Disease in its Rules and Regulations Governing Reportable Diseases. The State Health Department is in the process of reporting three cases of AIDS -- two which were found through the tuberculosis control program and another reported from the University Medical Center.

Competition Action Plan from AMA

Chicago, IL - The AMA's Competition Action Plan will provide physicians with information on practice opportunities as well as on financial resources for organizing a practice. A new Dept. of Physician Practice Services will serve as a clearinghouse of information on practice management programs, negotiation services, legal or financial assistance, placement services, and advertising or other general marketing programs.



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ORIGINAL PAPERS

Sarcoidosis Presenting as Massive Splenomegaly

SERGIO GONZALEZ, M.D.

Laurel, Mississippi

SARCOIDOSIS IS A CHRONIC granulomatous disease of the lymphoreticular system. Although nothing certain is known about its nature, it is generally thought to be an unusual manifestation of an immunological response.

It is important to note that sarcoidosis is a systemic disease, and that while it may present clinically with local manifestations (as in this case) these are always part of a process involving, or potentially involving, other organs and tissues throughout the body. Correspondingly, the histologic findings of a sarcoid granuloma where there is no evidence of generalized disease must not be interpreted as a manifestation of sarcoidosis without confirmation by further clinical, radiological and laboratory studies.

Case Report

A 32-year-old black female with six weeks symptoms of gallbladder disease was admitted to the surgical service of a county hospital in September 1977 for evaluation. The past medical history revealed no serious illness and no medication. Physical examination on admission demonstrated a left upper abdominal mass and right upper quadrant tenderness. Chest

was clear, cardiac NSR without murmur. Electrocardiogram and chest x-ray were negative, but abdominal series and gallbladder series revealed a massive splenomegaly. The CBC and SMAC were within normal limits except for a slight increase in gamma globulin fractions; IgA, IgG and IgM were increased, but no monoclonal peak was present.

At laparotomy a large spleen weighing 3,200 gms was found. The liver was not enlarged or nodular in appearance; no lymphadenopathy was seen. The gallbladder appeared diseased and was removed, as well as the spleen. A liver biopsy was also performed.

After surgery the patient recovered uneventfully. Now at five year follow-up, the patient reveals lung involvement. The IgA is still slightly increased, but IgG and IgM are within normal limits.

Historical Review

Sarcoidosis has been known for almost two centuries. The earliest clinical description of the disease is generally conceded to be Besnier's description in Paris, in 1889, of "Lupus Pernio."¹ The first pathologic description was given by Tenneson, also in Paris, in 1892.² About the same time in London, Hutchison described Mortiner's malady, named after his patient, Mrs. Mortiner, who refused to have a biopsy done, thus depriving him of examining the

Dr. Gonzalez is engaged in the private practice of pathology in Laurel, MS.



Figure 1. Marked splenomegaly due to sarcoidosis.

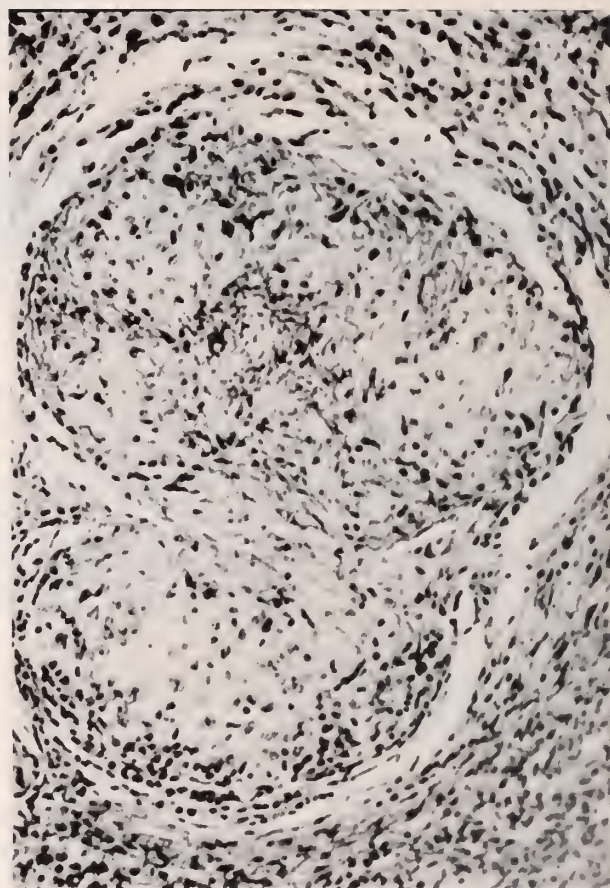


Figure 2. Tubercle-like granuloma within splenic pulp.

histologic changes.³ The disease as still usually known, Boeck's sarcoid, comes from Cesar Boeck who in 1899 interpreted the lesion as "Multiple Benign Sarkoid of the Skin."⁴ By 1916 Boeck reported that his "Benign Millitary Lupoid" and Besnier's lupus pernio was not a disease localized to the skin, but a widespread disease.⁷

The first published acknowledgement of internal organ involvement (the spleen and lungs) was by Kuznitzky and Bihoy in 1915.⁸ The sharply outlined osteolytic foci in the bones of the hands (and elsewhere) that are so characteristic a feature of some cases of sarcoidosis were first described by Kreibich, of Prague, in 1904.⁵ Priority in describing the skeletal changes is mistakenly credited to Jungling with his report in 1920 of "Ostitis Tuberculosa Multiplex Cystica."²⁰

The involvement of the unveal tract (vascular tunica) of the eyes was first described by Hearford, of Copenhagen, in 1910,⁶ as "uveoparotid fever," subsequently reported by Bruinslot in 1936, and Pautrier in 1937.⁹ A recent historical development has been the recognition of the frequency of involve-

ment of the pulmonary hilar nodes, and its association with erythema nodosum, by Lofgren in 1946.⁷

Pathology

Sarcoid granulomas are composed of epithelioid histiocytes with or without multinucleated giant cells. They are not known to be caused by an identifiable organism. They always appear in the periarterial lymphatic sheath in close apposition to central arteries or their branches or are intimately associated with penicillary arterioles as they extend into the red pulp. Their apparent occurrence only in conditions resumed or proved to be associated with an abnormal or defective immune response suggests that they may represent an alternative or compensatory mechanism for the handling of antigen. The fact that they occur exclusively in splenic areas that have been demonstrated to trap and concentrate antigen (the marginal zone of the periarterial lymphatic sheath) supports this suggestion.^{15, 17} The positive Kveim reaction also provides strong grounds for the antigen-antibody reaction hypothesis of this syndrome. As in this case, there seems to be a rise in

IgA, IgM, and IgG in most other cases. It has also been found that IgA readily polymerises or binds with other proteins. Accordingly, IgA antibody binds with different kinds of cells, causes tissue reaction and, hence, plays the major role in the formation of granuloma.

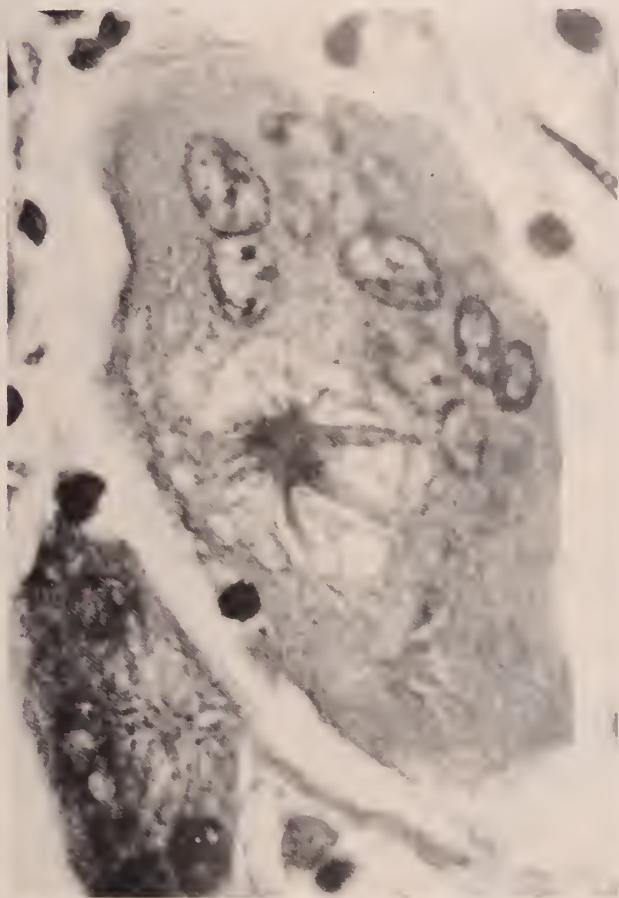


Figure 3. Stellate shaped asteriod body within a giant cell.

Discussion

Whereas formerly most cases of sarcoidosis were recognized because the patient came for advice about a cutaneous, ocular lesion, or enlargement of superficial lymph nodes, the wide use of chest radiography in the past two decades has disclosed many instances of the disease among patients without symptoms.

In a study of 275 cases of sarcoidosis, 34% were recognized because of chest x-ray findings without respiratory symptoms and 28% presented with respiratory symptoms, a total of 62%. Of the remaining cases, 11% presented with erythema nodosum; 5.5% with sarcoid lesions of the skin; 10% with ocular symptoms; 3.5% with enlargement of superficial lymph nodes; and 4% with tiredness, malaise or fever.¹⁹

Extensive disease may be present in the patients who feel perfectly well. While the prognosis in general is good, this must not be taken as grounds for either doctor or patient to disregard the potential seriousness of the disease, particularly in relation to the possible development of fibrosis of the lungs.

★★★

608 Second Avenue (39440)

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Shattuck Lecture* — The Increasing Supply of Physicians, The Changing Structure of the Health-Services System, and the Future Practice of Medicine†

ALVIN R. TARLOV, M.D.

Chicago, IL

THIS PAPER describes the social processes that promoted a doubling of the capacity of the medical schools between 1965 and 1980 and a projected doubling of the number of actively practicing physicians between 1970 and 2000. This rapid increase in the supply of physicians is analyzed within the framework of other forces for change in the health-care system. Health care in the 1990s will be provided within a more formalized and structured health-services system. Medical practice will be affected greatly.

In this presentation facts will be presented and observable trends will be described. Changes in the characteristics of the overall health services will be projected. Value judgments, good or bad, have been deliberately avoided. They are left to the reader. Rather, the intent is to help the medical profession see itself more clearly in the light of the changing social structure in which it operates.

The Increasing Supply of Physicians

More Doctors Needed: The Development of a Social Consensus, 1959 to 1970‡

*Presented to the 202d Annual Meeting of the Massachusetts Medical Society, May 18, 1983.

† Reprinted by permission of the *New England Journal of Medicine*, 308:1235, 1983.

‡ Some of the material in this section was presented in a different context at a conference on "Academic Medicine: Present and Future," sponsored by the Rockefeller Archive Center, May 1982.¹

Alvin R. Tarlov, M.D., was a featured speaker at MSMA's March leadership conference, "Health Issues in the 80s." The following article includes the text of Dr. Tarlov's address. It is reprinted for the benefit of MSMA members who were unable to attend the March symposium and in response to many requests from conference registrants for copies of Dr. Tarlov's remarks.

New directions in health services in the United States have been undertaken since a broad social consensus favoring the directions has been developed. A social consensus has often been activated through joint undertakings by the private sector and the government. The private sector, through committee and commission reports, analyzes information and makes recommendations. The government, acting from a base of public acceptance, provides funds for implementation. In the past 25 years one result of reaching and acting on a social consensus through combined private and government activities has been a substantial increase in medical-school enrollment.

In 1959 the Bane Report to the surgeon general advised that the physician-to-population ratio of 141 to 100,000, unchanged since 1940, could not be maintained unless the medical-school (allopathic M.D. and osteopathic D.O.) graduating class size

were increased from 7400 to 11,000.² The report advised enlargement of the existing 85 allopathic and 6 osteopathic schools and the establishment of 20 to 24 new medical schools. Urgency was expressed:

probably the greatest immediate obstacle to expanding the nation's medical educational capacity in existing schools and in the development of new schools is the problem of financing the needed physical facilities . . . the Consultant Group is convinced that the nation's physician supply will continue to lag behind the needs created by an increasing population unless the federal government makes an emergency financial contribution on a matching basis towards the construction of medical facilities.

Four years later, through the Health Professions Educational Assistance Act of 1963, Congress provided construction funds. The objective of expanding the size and number of medical schools was accomplished, although federal support for their operating costs was deliberately avoided.

Added enthusiasm for increasing the supply of physicians was provided in 1964 by the Coggeshall Report to the Association of American Medical Colleges.³ Coggeshall, quoting from the report of the President's Commission on Heart Disease, Cancer and Stroke, wrote, "The first hard fact to be faced is that there is not enough health manpower to meet the needs of the American people. There are not enough doctors and not enough supporting people.'" The Coggeshall Report acknowledged the recent increase in the capacity of the medical schools but noted that the increase in the supply of physicians was not commensurate with the need. The report concluded, "In light of the growing need for physicians, despite the hopeful off-setting factors, it is clear that more physicians must be trained as quickly as possible. . . . It must be recognized, however, that it is not likely that America will ever be able to produce all the physicians that the nation would like to have." Like the Bane Report, the Coggeshall Report also conveyed urgency.

The decision by the Supreme Court in 1954 in *Brown versus Board of Education* and the Voting Rights Act of 1965 bracketed a decade of debate on the concepts of rights as specific entitlements. Evolving during that period was the concept of the right to health care, for which the capstone was the Medicare and Medicaid legislation of 1965 and 1966, which promised equal access to high-quality health care for the aged and the poor. The Medicare-Medicaid legislation created concern about the adequacy of physician manpower to fulfill the national promise.

In 1966 the President of the United States estab-

lished the National Advisory Commission on Health Manpower, chaired by Mr. J. Irwin Miller, "to develop appropriate recommendations for action by government or by private institutions, organizations, or individuals for improving the availability and utilization of health manpower."⁴ The blue-ribbon commission reported in 1967,

The production of physicians should be increased beyond presently planned levels by a substantial expansion in the capacity of existing medical schools and by continued development of new schools. Federal funds in support of capital or operating costs of education should be provided to a medical school in such a way that they create economic incentives for the school to expand enrollment while improving its quality. Such incentives should be based on increases in absolute numbers of medical students.

On March 5 and April 16, 1968, shortly after the Miller Report was published, joint statements were released by the American Medical Association and the Association of American Medical Colleges.⁵ The statements read,

To meet national expectations for health services, the enrollment of our nation's medical schools must be substantially increased. At a joint meeting held in Chicago on February 28, 1968, the representatives of the Board of Trustees of the American Medical Association and the Executive Council of the Association of American Medical Colleges emphasized the urgent and critical need for more physicians if national expectations for health services are to be realized. National policy which would best meet this need and would be consistent with the American ideal of equal educational opportunity for all would provide such resources that every young person interested in and qualified for entry to the study of medicine would have this opportunity. Both associations endorsed the position that all medical schools should now accept as a goal the expansion of their collective enrollments to a level that permits all qualified applicants to be admitted. As a nation, we should address the task of realizing this policy goal with a sense of great urgency.

These two associations recommended that increased funding be made available to support the educational component of academic medical centers and that the production of an increased number of physicians be assigned the highest priority. Their support was important to the passage of the Health Manpower Act of 1968.

The Health Manpower Act of 1968 provided loans and scholarships for medical and other students in the allied health professions and funds to medical schools for facility construction, operating costs, and educational innovation (a three-year rather than a four-year course of study) linked to a requirement to increase their class size (capitation grants). Expansion of the physician supply received further impetus from this legislation.

More encouragement for expansion was provided in 1970 by the Carnegie Commission on Higher Education. In *Higher Education and the Nation's Health* (the Clark Kerr Report),⁵ the commission, expressing urgency, recommended a 50 percent increase in medical-student enrollment (this recommendation was achieved in the next 10 years), enlargement of the medical-school-teaching-hospital role to the status of academic medical centers, and the development of Area Health Education Centers to help improve services in sparsely populated areas. These recommendations were influential in the health-manpower bills enacted by Congress in the first half of the 1970s.

Each of the four reports issued during the years 1959 to 1970 — Bane, Coggeshall, Miller, and Kerr — expressed a sense of national urgency, recommended rapid and vigorous action to increase the supply of physicians, and resulted in federal authorizations and appropriations designed to implement their recommendations. A national consensus had developed on the need to alleviate the shortage of physicians.

Two critical questions — how many physicians were needed, and how many students should be admitted to the medical schools each year to meet the nation's needs in an orderly fashion — were not addressed. A shortage was agreed on. Corrective measures without limits or targets were rapidly implemented.

The Response: Medical-School Admissions, 1965 to 1982

The number of medical schools increased from 94 to 142. The first-year enrollment increased from 9,018 to 18,248 (Table 1).

During this same period, encouraged by changes in immigration regulations designed to correct the perceived shortage of physicians, there was a substantial influx of foreign medical graduates, predominantly non-U. S. citizens, into the United States. Foreign medical graduates occupied approximately 25 to 30 percent (4400 to 5400 per year) of the first-year residency training positions and received 17 to 46 percent (3100 to 6700 per year) of the initial licenses issued by the state boards of medical examiners during this 17-year period.⁸

The Response: Practicing-Physician Supply, 1978 to 2000

An approximate eight-year interval occurs between entry into medical school and entry into practice. The sharp increase in first-year medical-school enrollment during the late 1960s and the 1970s had

TABLE 1
ENROLLMENT OF FIRST-YEAR STUDENTS IN U. S.
MEDICAL SCHOOLS, 1965-1982

Academic Yr*	Allopathic Schools†		Osteopathic Schools‡		Total First-Year Enrollment§	% increase from previous yr
	No. of schools	New 1st-yr enrollment	No. of schools	1st year enrollment	No.	
1965	89	8,554	5	464	9,018	
1966	92	8,775	5	480	9,255	2.6
1967	95	9,314	5	509	9,823	6.1
1968	99	9,740	5	521	10,261	4.6
1969	101	10,269	6	577	10,846	5.7
1970	103	11,169	7	623	11,792	8.7
1971	108	12,088	7	670	12,748	8.2
1972	112	13,570	7	810	14,380	12.8
1973	114	13,876	7	884	14,760	2.6
1974	114	14,579	9	905	15,484	4.9
1975	114	14,910	9	1,002	15,912	2.8
1976	116	15,282	10	1,068	16,350	2.8
1977	122	15,493	12	1,207	16,700	2.1
1978	125	16,054	14	1,322	17,376	4.0
1979	126	16,301	14	1,381	17,682	1.8
1980	126	16,590	14	1,478	18,068	2.2
1981	126	16,644	15	1,564	18,208	0.8
1982	127	16,567	15	1,681	18,248	0

* Beginning in September.

† Data obtained from the Association of American Medical Colleges, Division of Student Services. ‡ Students who were repeating the first year of medical school were excluded; only new entrants were included.

§ Data obtained from the annual yearbooks of the American Osteopathic Association. ‡ Students who were repeating the first year of medical school were not excluded.

§ Includes only new enrollees in the allopathic schools, and new enrollees plus students repeating the first year (approximately 4 percent of the total first-year class) in the osteopathic schools.

only a modest effect on the practicing-physician supply during that period. However, by 1990 there will be a 43 percent increase as compared with 1978 (Table 2). The number of practicing physicians will continue to increase in the 1990s despite a leveling or a decrease in the first-year enrollment in the mid-1980s, because the recent large addition of new physicians will shift the mean age of the total physician population toward relative youthfulness. New additions to the pool will exceed attrition because of death, disability, and retirement.

The increasing supply of physicians will not be distributed among specialties according to logic or a plan. The number of residency training positions in each specialty is not based on a careful consideration of national needs. Large numbers of newly trained practitioners will be added to the internal-medicine

subspecialties and to the various surgical fields.^{1, 9} The health-care system of the 1990s, when the supply of physicians will be more plentiful, will require an accommodation to the presence of greater numbers of highly specialized physicians. Some fields, such as psychiatry,⁹ preventive medicine,⁹ and physical medicine,¹⁴ will continue to be undersupplied. Specialty distribution, although of high importance, will not be addressed in detail in this paper.

How Many Physicians Are Needed?

Many methods have been used to estimate the number of physicians needed: physician-to-population ratios, the number of physicians employed in "closed" systems of care, a percentage of the gross national product, and various mathematical models based on either the demand for medical services (current use rates projected to the future) or the needs (idealized) for services.

The most widely used method is the physician-to-population ratio, expressed as the number of physicians per 100,000 population. From 1940 to 1959, there were 141 physicians per 100,000 population in the United States. In 1959 Bane recommended maintaining that ratio. By 1990 we will have a ratio of 215 per 100,000 (Table 2).

Several closed systems for delivery of comprehensive health services to a fixed population provide experiences from which the needed number of physicians in each specialty can be estimated. The Kaiser-Permanente System, other large health-maintenance organizations, and the military services are some examples of closed systems.

Some of the European nations¹⁵ set annual limits on expenditures for health care as a percentage of the gross national product or of the national budget. They then target their health-manpower requirements according to the fixed expenditure.

The Adjusted Needs Based Model was developed by the Graduate Medical Education National Advisory Committee (GMENAC).^{9, 16} This model employs an elaborate data base of the most current information on the incidence and prevalence of each disease or condition, the norms of care for that disease or condition, and measures of physician productivity. Current data are then adjusted by a panel of experts to 1990 or to another year within the context of what can be reasonably expected by that time on the basis of current trends and foreseeable developments. The Adjusted Needs Based Model was used by GMENAC to estimate the 1990 requirements for physicians. A decade or more of experience will be required to assess the assumptions and

TABLE 2
U. S. PHYSICIANS, POPULATION, AND
PHYSICIAN-TO-POPULATION RATIO*

	1970	1978	1990	2000
Physician supply†	310,000	374,800 (21)	535,750 (43)	642,950 (20)
U. S. population in thousands‡	203,235	218,717 (8)	249,731 (14)	267,990 (7)
Physicians per 100,000 population	152	171 (12)	215 (26)	240 (12)

* Numbers in parentheses are percent increases over value for the previous period.

† Includes all professionally active physicians (M.D.s and D.O.s), together with 0.35 of all residents and fellows in training in the year indicated. The figures for 1978, 1990, and 2000 are taken from the report of the Graduate Medical Education National Advisory Committee.⁹ The rationale on which the 0.35 adjustment for trainees is based and the assumptions used for estimating the supply for 1990 and 2000 are in the committee's report. The figure for 1970 is taken from an American Medical Association publication.¹⁰

‡ U. S. Bureau of the Census: 1970¹¹; 1978¹²; and 1990 and 2000.¹³

validity of the model. GMENAC estimated that in 1990 the supply of physicians would exceed the adjusted needs by 70,000.

All the methods for estimating requirements for physicians have value, and all have shortcomings. Nonetheless, the expected 1990 supply of 535,750 actively practicing physicians in the United States, with a physician-to-population ratio of 215 (Table 2), is judged by most students of this problem to exceed the need.

The Industrialization of Medicine

The rising supply of physicians, even if it were the only change, would have some undesirable effects. Most notably, costs per capita and aggregate costs of health care would increase. However, society has expressed alarm at the ever rising cost of health care. New attempts to control these costs are being made energetically and on a large scale. Almost all these attempts tend to industrialize the health-care system. What was an informal arrangement whereby individual physicians working in independent practice ministered to individual patients is in the process of transformation to a formalized, highly structured service industry whereby groups of health workers render health services to groups of customers by contract. Group purchasing of services in a competitive market requires that the health outcomes from those services be explicit and evaluable. This formalization, or industrialization, could not occur

without a rapid rise in the number of physicians. The combination of formal industrialization of the health-services system, the demand that the health outcomes of care (benefit related to cost) be explicitly gauged in socially relevant terms, and the effect of a rapidly rising physician supply on physician preferences for employment promises to have major consequences for the practice of medicine.

The Formal Industrialization of the Health-Services System

The principal components of the health-services system are the facilities, the patients, the payer-underwriters, and the physicians. These components have assumed varying degrees of corporate or corporate-like organizational structures and operations. The interplay of these components is assuming the characteristics of an integrated industry. More than \$300 billion a year — more than 10 percent of the gross national product — is expended in this system. Health care has become the nation's largest industry.

The Facilities

Sharp changes in the corporate structure of the nation's 7000 hospitals are occurring. About one third of the hospitals have formed multihospital systems (horizontal integration) wherein they have advantages in marketing services, savings through bulk purchasing, and improved capital development for equipment purchases, renovation, and new construction. The largest of these multihospital chains are for-profit (Hospital Corporation of America, Humana, American Medical International), with for-profit beds now comprising about 11 percent of the national total.¹⁷ Seventy-five percent of nursing homes already are for-profit. Corporate restructuring of hospitals also occurs as they attain ownership of health-promotion centers, ambulatory-care centers, diagnostic centers, satellite facilities, rehabilitation facilities, and nursing homes (vertical integration). Nonprofit hospital corporations may own subsidiaries that are for-profit, such as restaurants, hotels, and rental property. The drive toward "unbundling" of operations and revenues from these various sites in order to escape government cost-reimbursement regulations imposed on hospitals often converts the corporate structure to that of a holding company. One result is that a community hospital may no longer be governed by a local board of trustees. Responsibility for institutional planning, operations, and appointment to top administrative posts may be assumed by central management and a board of directors far removed from the community in which the hospital resides. In brief, the facilities

through which about half of all health costs are expended are assuming the characteristics of a mature industry with aggressive activities centered on mergers, capital development, investment, and profit. One might wonder whether the social purpose, which motivated the community hospitals of the past, will emerge with any influence in these newer structures, or whether a loss of social purpose will affect the outcome of services to patients.

The Patients and Payer-Underwriters

The usual process by which a patient paid for health services in the earlier part of this century involved a direct transaction between the patient and the doctor, pharmacist, or hospital cashier. The advent of health insurance and third-party payers, however, has distanced the patient from that transaction. The money for most health-related purchases is now provided by large corporate entities, such as manufacturing concerns, other employers, and governments. In between the money providers and the patients has grown an underwriting complex of huge insurance companies, including Blue Cross, Blue Shield, Prudential, Aetna, and many other insurers, whose social function is to distribute the financial risk over all enrollees and to facilitate the transaction between the patient and the health-service provider.

Increasingly, employees and other patients are offered a choice of combinations of underwriters and providers. These combinations, or health-care plans, compete for employee groups and negotiate with physician corporations and hospitals for the broadest services at the lowest price. Blue Cross of California, with four million enrollees, will market a plan, beginning July 1, 1983, with a reduced premium requiring that the enrollee agree to use selected hospitals and physicians. Blue Cross has conferred select status on about one third of the state's hospitals. Physicians on the medical staff of these hospitals may apply for select status, but they will have to agree to fixed fees, advanced approval of hospital admissions, and review of their care. Marketing forecasts predict that 80 percent of the enrollees will elect coverage under the Prudent Buyer Plan.

Some physician groups have entered the competition by establishing a variety of organizational structures and numerous cost-savings arrangements. These physician groups include health-maintenance organizations, independent-practice organizations, and preferred-provider organizations, which offer services at a cut rate to selected employee groups. The underwriter-provider plans compete with each other by offering different arrays of coverage, de-

ductibles, copayments, limits, premiums, physician groups, and hospitals. The patients' aggregate purchasing power, acquired by selecting one plan from many offered, may select or even determine the services provided, the physician group to be contracted with, and the hospital to be used. The patients then become bulk purchasers of services. In the aggregate, the patients behave as a corporation.

Industrial concerns, often the payers of health services, have inserted themselves as active forces in the changes taking place in the health-services system. Competitive disadvantage in pricing their products and awareness of what is perceived to be runaway cost increases in their health-care benefits have led some corporations to take more direct and aggressive action to contain costs. (For example, Chrysler has complained that health-care benefits for its employees add \$350 to the price of each automobile,¹⁸ and Ford reported that it expended \$710,000,000 on health-care benefits in 1981.¹⁹) One example of aggressive corporate action is the formation in Alabama of the Birmingham Health Care Coalition, which comprises 11 corporations and works with area physicians to contain costs²⁰ by restraining use, mandating that specified surgical procedures be accomplished on an ambulatory basis, and restricting hospitalization.

Health Outcomes: Public Expectations of the Health-Services System

The medical objectives of an era emanate from two formative influences. The first relates to the state of the art in the medical science of the period, which provides an understanding of disease processes and therapeutic modalities for successful intervention. The second is society's expectation of health care. These two influences coalesce to make explicit the social purpose of the system. Each era of medical objectives builds on the last. The eras overlap considerably.

The period from 1800 to 1980 was the era of epidemic-death prevention. The major focus was on infection. The diseases included smallpox, the plague, cholera, typhoid fever, influenza, polio, tuberculosis, venereal disease, and many others. The central objective of medicine was to prevent death. Beginning in London in 1800 with William Jenner, who developed the smallpox vaccine, extraordinary success was accomplished during this era as vaccines, sanitation methods, chemotherapy, and antibiotics brought deaths from epidemics under control. Noteworthy was the recent announcement by the World Health Organization that smallpox has been eradicated from the entire world.

The central medical objective of the period from 1940 to the present and into the near term is the correction of physiologically measurable abnormalities. Biomedical research has made possible a remarkable understanding of human physiology and biochemistry and their derangements. Clinical physiology has become an exact science. Departures from physiologic normalcy can be detected and measured with precision in exact units, such as millimeters of mercury, liters of gas, ejection fractions, milliequivalents of ions, and even single amino acid substitutions in faulty enzymes and single nucleotide substitutions in DNA molecules. Concurrently, the pharmaceutical industry has developed potent medications to help correct physiologic and biochemical aberrations. The medical-electronics industry has provided mechanisms for appropriate monitoring of the internal milieu as corrective action is undertaken. So successful has been the era of correction of physiologic measurements that the objectives can easily be accomplished on an almost routine basis.

A new era is beginning wherein neither the prevention of death from epidemics nor the correction of physiologically measurable abnormalities will be the principal medical challenge. The central objective in the coming era will be the maintenance or improvement of individual patient functioning in the patient's normal environment while he or she performs usual activities. The emphasis on patient functioning is partly founded on probing inquiries that ask whether the high cost of health care is yielding a proportional benefit in health. Public skepticism of the highly technical nature of medical practice and the emotional distance that has grown between the patient and the doctor as the technology has become more powerful may also contribute to a new focus on functional objectives and the concept of the quality of life.

The outcomes of medical services of greatest interest to the patient and to society relate to the patient's ability to function at a high level in personal activities. These abilities include self-care in the usual activities of bathing, dressing, and eating; mobility; physical activity; and optimal function in the role of homemaker, spouse, parent, employer, supervisor, community participant, or citizen. Patients' perceptions of their health status and of their mental health bears directly on their functioning. Satisfaction with health services and reasonable expenditures for the services are also of interest. To optimize these outcomes of care will be medicine's central objective for the period ahead.

Currently, the attention of the purchasers of

coverage and the managers of plans is concentrated on process indicators, such as access to care, and on the specific services covered in the plans. It appears likely that process and coverage will assume less attention in the benefit-cost equation of the future, whereas improved patient functioning per unit cost of services will be highlighted. This change in the public's expectation of health care will affect the patients' expectation of their plan and the doctor-patient interaction.

Physician Preference in a Period of Rapidly Expanding Supply

The increasing supply of physicians is felt by young residents in training as they search for a place to practice. Residents are finding that many areas are already saturated with physicians, the competition for patients is very high, and many hospitals are unwilling to accept additional doctors on the medical staff.

One result is the favor with which new physicians look on salaried positions in an increasingly competitive environment. Ensured practices and income are available in incorporated structures, such as health-maintenance organizations; large multispecialty group practices; hospital ambulatory, emergency, critical-care, and subspecialty-procedure facilities; manufacturing concerns; the military and the Veterans Administration; and other public institutions. Young physicians are demonstrating a willingness to sacrifice income in favor of regular hours, protection from the most demanding elements of practice, fast start-up at no personal expense, ensured salary, and protection from competition. The Physician Practice Study, supported by the Robert Wood Johnson Foundation, found that institutional salaried practice was the main professional activity of 15 percent, 23 percent, and 31 percent of newly trained family physicians, general internists, and subspecialty internists, respectively.²¹ The American Medical Association found in a 1981 survey that one fourth of all practicing physicians (residents excluded) had a contract with a hospital to provide services and that these physicians typically derived 62 percent of their annual income from these arrangements.²²

Health-maintenance organizations, to the extent that their growth has been impeded by lack of physician enthusiasm, may enjoy even sharper growth in the future. A report by Interstudy, Minnesota, showed that on June 30, 1980, there were 9.1 million health-maintenance-organization enrollees, an increase of 10.6 percent over the previous year; that on June 30, 1981, there were 10.3 million enrollees,

up 12.8 percent; and that on June 30, 1982, there were 10.8 million enrollees, up 5.5 percent.²³

The increasing aggregation of physicians in institutional-type practice and in salaried positions will encourage them to sacrifice some professional autonomy for their collective interests.²⁴ Collective bargaining by physicians with the management corporation will become common. The physicians' organization becomes formalized with "worker intent." Will the social purposes for which the profession has existed be subordinated to the interests of the organization or the corporation?

The influx of new physicians into practice will be sustained at high rates throughout the 1980s. By 1990, approximately 40 percent of all practicing physicians will have entered practice since 1978. The effect of the rising number of physicians and the favorable attitude of new physicians toward employment suggest that the profession, by and large, will be providing services in a system quite at variance with what individual physicians and the profession as a whole have experienced in the past. Physicians will become less powerful and will represent only one component of this system for negotiating the terms of health services on a large scale. The other components include employers from the manufacturing sector, whose revenues provide the money for health-care purchases; labor unions, which negotiate the level of management's contribution to the health-care fund; governments, which in 1981 underwrote 42.7 percent of the total expenditure; underwriters, who manage the payment system; plans, through which patients will express their preference; corporations, which own the facilities in which about half the costs are incurred; and physician groups, whose incomes account for 20 percent of total health-care expenditures.

Consequences

The rise of a complex of interacting corporations that own the facilities, underwrite the cost of care, manage the plans, and employ or retain physicians will have important consequences. Health services may become more accessible, and the services more efficiently organized. Prepayment and competition for patient enrollees may allow the poor and the elderly to be brought into the mainstream of the medical-care system. Restraint will govern the use of marginally beneficial tests. Health-care costs could be contained within socially acceptable limits.

The likelihood of establishing a uniformly structured health-services system in the United States in 1983 or thereafter is remote. In place is a highly variable system having multiple organizational,

political, and economic components. Regional, state, and local variables have been built in. Within this pluralistic system, nevertheless, the facts that most physicians will be practicing within a corporate structure and that a large fraction of their income will derive from prepaid capitation contracts will bring about modifications in (1) the social organization of physicians' work, (2) the concept of health, (3) the way in which clinical decisions are made, (4) the patient's participation, (5) the physician's accountability, and (6) the determinants of physician supply and specialty distribution.

The Social Organization of Physicians' Work

In the future, cost containment and health services by contract will be the driving forces that will tend to create an employee orientation among the physicians. The mechanism for cost containment will be restraint of use through prepayment of premiums, with physicians sharing the financial risk, and deductibles and copayments, which give patients a direct stake in costs. The annual revenues of a plan will be known in advance. The physician's share of these revenues will rise as he or she diminishes the use of hospitals and expensive procedures. The patient's incentive is to reduce the use of health services in order to diminish direct out-of-pocket expenditures. Both physicians and patients, therefore, rather than being insulated from the economic consequences of use, as they have been under cost reimbursement and the "usual-customary-reasonable" systems, will have a direct self-interest in shifting the patterns of care toward restraint.

A hierarchical structure will develop in large physician-employing organizations, with some physicians shifting from patient care to management. The management contingent in the health-care industry is likely to grow substantially, and manager-physicians may become an important part of the profession. A bureaucratic system of governance will develop. Physicians' corporations will negotiate with other corporate structures. The corporations will control the composition of the medical staff with respect to total numbers and specialty distribution. Physicians will probably often change their place of employment, moving, for example, from a preferred-provider organization to a health-maintenance organization, to a hospital, to a home health-care agency, or to a management corporation.

The Concept of Health and the Effectiveness of Care

Questions are being raised, especially regarding the Medicaid population, about the relation between

efforts to decrease use of health services and the effect on individual health. The questions remain unanswered because of the absence of an operationally meaningful definition of health.

A resolution was made at the Thirtieth World Health Assembly in May 1977.²⁵ It declared "the main social target . . . in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life." Implicit in that declaration is the assembly's definition of health in terms of the functioning of individuals.

During the past decade the young field of health-services research has developed sophisticated measures of personal, social, and economic functioning. The quality-of-life concept is beginning to take shape in terms that can be assessed. It is now possible to assess the outcome of health services by measurements of patient functioning in personal care, physical activity, role fulfillment, mental-health status, perceived health status, and economic productivity. These measurements can be supplemented by assessments of patient satisfaction with care, the cost of care, and disease status. The large public and private institutions for cardiovascular and cancer research, which assessed outcomes primarily in terms of mortality and morbidity statistics in the past, are beginning to turn some attention to assessments in functional terms.

I believe that the newly formed health-care corporations and coalitions, once they have been successful in reducing the volume of patients and the costs of services, will react to pressure and establish mechanisms to assess patient outcomes in functional terms. The success of the corporations and plans will be gauged by these assessments. The functional capability of his patients will become the major focus of the physician's practice.

Clinical Decision Making

In the past, an individual physician exercised broad discretionary powers in organizing his or her practice and managing patients. The physician would decide, in conversation with the patient, which tests to perform, what treatments to undertake, and when to hospitalize or discharge a patient. Decisive information on "the right way" to approach most medical problems has not been developed, partly because measurement of outcomes of medical services has not been applied. Therefore, promulgation of local conventions or individual physician preferences, sometimes influenced by the local availability of services but always left largely

to the physician to decide, has governed the rate of use of health services. More than threefold variations in use rates from one locale to another, even in adjacent communities, have been convincingly demonstrated by Wennberg and Gittelsohn.²⁶

In corporate medical practice, however, such wide latitude will be systematically diminished by prepayment, competitive pricing of premiums, deductibles, copayments, corporate hiring policies, and corporate rules of practice. Corporate rules and algorithms will govern physician practice habits. The frequency and intensity of preventive and early detection services and the use of diagnostic tests will be prescribed. In some plans surgery on an ambulatory basis is already mandated.²⁷ Preadmission certification — that is, corporate preapproval of hospitalization, mandatory preadmission testing, avoidance of Friday and Saturday admission, and allowable length of stay — is determined by the corporate rules of practice.²⁷ The corporation will decide which specialists will provide primary care. Roles will be defined for generalist physicians, specialists, nurse practitioners, psychologists, and others. As an example, the Group Health Association of Washington, D. C., announced in December 1982 that in its plan most infant deliveries would take place in birthing centers under the direction of nurse midwives.²⁸

The above examples are not isolated occurrences. Rather, these corporate rules of practice are in operation in all areas of the country in most of the newly developed health-plan options that operate on a pre-paid basis. The result is to reduce individual physician discretion in clinical decision making.

Patient Participation

Patients can be expected to play a more active part in their health care. They will choose their plan, their physician or physicians, and their hospital. Patients may also exercise their options to change plans or to select a new doctor. They will be aware of their health-services benefits and will expect services to be provided at their call. They will control their use of the system and their physicians' use of tests, procedures, drugs, and hospitals. An emphasis on disease prevention and health promotion, and the patients' awareness of their functioning, will enhance the patients' understanding of their important role in achieving good health.

Physician Accountability

Formerly, a physician and a patient developed a covenantal relationship in which the patient's well-being was supposed to be the dominant consideration. Multiple accountabilities will soon distract

from that simple relationship. The physician will be accountable to the underwriting plans, to restrain costs; to the hospital, to help make it financially viable; to the health-services corporation, of which he or she may be a partial owner; and to governments. These accountabilities will be reinforced by preset quantitative expectations of physician productivity and regular feedback on performance data, and perhaps by penalties. Working agreements, such as a 40-hour week and weekend coverage, may further contribute to the erosion of the traditional sense of the physician's personal responsibility for the patient. The patient will become a client of the corporation. The physician's attentiveness to the patient could become an effort to maintain good business.

The Determinants of Physician Supply and Specialty Distribution

The aggregate number of physicians in the United States has been determined by the size of the entering class of the nation's medical schools and by immigration and licensing procedures, which have favored the foreign medical graduate who wants to train and practice in the United States. These determinants reacted in the 1960s and 1970s to a national consensus that more physicians were needed.

The sizes of the residency and fellowship training programs in each specialty ultimately determine the number of practicing physicians in the specialty. The size of the training programs has been influenced substantially by the need for clinical services in each teaching hospital, determined independently. Consideration of the national need for specialists has not been an effective determinant.

There are limits on a community's capacity to absorb new physicians in each specialty. Newhouse and colleagues have demonstrated an effect of saturation.²⁹ However, there is substantial elasticity in the absorptive capacity. The elasticity derives from three factors: the uncertain efficacy of a large part of medical practice, which allows wide variations in the use of medical services per capita in each locale; the fluid boundaries between specialties, with specialists assuming generalist functions when there is insufficient specialty work to fill a practice; and the lack of effective restraints on use rates or on the use of specialists' services in health-insurance plans of the past.

In most European countries, the elasticity hardly exists. Those countries have established fixed numbers of practice positions in each specialty and in each region. These positions are now saturated. Continued training at rates higher than needed to replace loss through death, disability, and retirement

has led to unemployment of physicians.¹⁵

Although a fixed-capacity system is not in sight in the United States, there will be a reduction in the elasticity. Each medical-service corporation will define the tasks to be performed by each specialty. The organizations will specify precisely the numbers of physicians in each specialty that they will accept. Opportunities outside this organized structure will be available, but they will become limited in scope and in geography, as compared with today.

The net result will be more effective pressure from the practice world on the teaching hospitals and medical schools to adjust their enrollments and the size of their training programs to meet the system's newly circumscribed needs.

Recommendations

Social systems often evolve slowly, sometimes rapidly. Several social forces intersecting at a critical time cause more rapid change. The health-care system and the practice of medicine have entered a period of rapid change. The forces that are propelling this change are formidable. Whether or not the changes should occur is an interesting but not central question. How to adapt and ensure that the result serves the larger social purpose more effectively is the greater challenge. The following recommendations are a general attempt to address a few of the complex issues brought about by a fundamentally restructured health-services system.

The Doctor-Patient Relationship Should Be Reconsidered

The doctor-patient relationship surely will be disturbed under the forthcoming formal organization of the health-services system. The doctor's intimate knowledge of the patient's past, biologic and social reactivities and endurance, surroundings, resources, ideals, and preferences, together with the patient's confidence that the doctor places the patient's personal well-being above all other concerns and the physician's almost unifocal accountability to the patient, constitute powerful resources for diagnosis and therapy.

However, the newer systems with their multiple accountabilities place a great strain on the traditional relationship between doctor and patient. The profession should undertake broad discussions of the doctor-patient relationship in order to adapt it to modern realities, while reinforcing the elements of the philosophy that are fundamental to effective physicianhood. The process by which a doctor-patient relationship is reconsidered should have broad visibility in order to gain the consensus of professionals and

the public about the physician's responsibility, the patient's responsibility, and the personal and social purposes of health care. Physicians and patients need a conceptual structure to guide their interactions. The profession should establish, perhaps through a joint effort by the American Medical Association, the National Medical Association, and the American Osteopathic Association, a broad multiyear forum for the formulation by physicians, students, patients, and philosophers of ideals to underlie the doctor-patient relationship of the future.

Medical Effectiveness Should Be Studied

Longitudinal studies should be undertaken to assess the outcomes of care when health services are provided under various plans that restrain use or have different emphases. Outcome assessments should include measures of self-care, physical activity, mobility, role fulfillment, perceived health status, mental health, disease status, expenditures, and satisfaction with service. Process variables and physician variables that are associated with the most successful outcomes should be identified and explained.

The Growth Rate of Physician Supply Should Be Restrained

In the past, some observers advocated an unlimited supply of physicians as a useful mechanism to create competition and thereby decrease cost and improve services. In the 1990s, however, other forces will more effectively constrain costs and improve services. No useful social purpose can be achieved by having more physicians than are needed. Demoralization of the profession will be beneficial to no one. Therefore, the following should occur: (1) New entrants to United States allopathic and osteopathic medical schools should be reduced from the present level of about 18,200 to approximately 16,000. (2) Minority enrollment in U. S. medical schools should be increased in proportion to the expected future representation of each minority group in the general population. A broad social consensus must be developed in order to achieve this. As a first step, a national colloquium should be convened of leaders in general education, medical education, science, business, religion, and government. The government should initially take the lead in organizing and financing this program. (3) U. S. citizens should be discouraged in the future from entering foreign medical schools by requiring that medical licensure be granted only to graduates of accredited U. S. and Canadian medical schools. The 13,000 Americans currently studying in the

"offshore" schools should be allowed to complete their studies, helped to gain entrance to accredited graduate medical-education programs in the United States, and licensed to practice after successful completion of examinations. The Federation of State Licensing Boards should assume leadership in this effort. (4) Alien graduates of foreign medical schools should be welcomed for training but denied licensure for permanent practice except if they are granted U. S. citizenship under a family-preference clause. The current rate of entry into practice of approximately 1500 alien graduates of foreign medical schools per year should not be exceeded.

A National Health-Manpower Policy Should Be Developed

A coherent national health-manpower policy should be developed. Although regional and local needs must be addressed, even the needs are dependent on the aggregate supply and demand. Reliable information and guidance are needed by high-school and college students, state legislatures, colleges and medical schools, teaching hospitals, professional associations, and the federal government. The policy must not focus on physicians alone but must integrate the manpower needs of all health professions that provide direct services to patients. The purpose of this policy-development program would be to help create a balance between the requirements for and the supply of personnel in each of the health professions in an integrated way. The program must have the broad data necessary for comprehensive manpower studies. The Institute of Medicine of the National Academy of Sciences appears to be the logical organization for this program.

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In summary, I have argued that twice in the past 20 years a broad social consensus has developed in relation to specific aspects of the health-care system. The first consensus identified a shortage of physicians and led to remarkably effective action to increase the supply. The second acknowledged that the costs of health care were rising faster than our economy could assimilate them, and led to the introduction of multiple cost-restraining mechanisms, most of which were based on a prepayment concept. The intersection in the 1980s and 1990s of a plentiful supply of physicians, the introduction of underwriting systems based on prepayment and shared risk, and the development of large corporations for health care is bringing about a fundamental restructuring of the health-services system and a transformation of the practice of medicine. Actions of this order that

restructure a system, taken for the greater good, always have some unintended, unanticipated, and undesirable effects. But the actions are generally forceful and rarely reversed, at least in the near term. We should understand the roots of these changes, be outwardly directed, and assist society in achieving its goals within the context of the social purposes for which the health-care system exists. ★★★

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Inflammatory Bowel Disease: Newer Developments in Medical Treatment, Pathology, and Operative Management—

is the title of a symposium for physicians to be presented October 14, 1983*, in Birmingham, Alabama.

The symposium, which will provide physicians with seven (7) hours of Continuing Medical Education (CME) credit, Category I, is sponsored by **South Highlands Hospital** and coordinated by Dr. Arthur M. Freeman, Jr. It will be held at the Birmingham Hilton — 808 South 20th Street, Birmingham, Alabama from 9:00 A.M. until 5:00 P.M.

PROGRAM PARTICIPANTS

- Joaquin S. Aldrete, M.D. - Professor of Surgery, Department of Surgery, The University of Alabama in Birmingham, School of Medicine.
- U.S. Senator Howell Heflin - (D) Alabama
- Basil I. Hirschowitz, M.D. - Professor & Chairman, Department of Medicine, The University of Alabama in Birmingham, School of Medicine.
- Patrick H. Linton, M.D. - Professor & Chairman, Department of Psychiatry, The University of Alabama in Birmingham, School of Medicine.
- Willis S. Maddrey, M.D. - Magee Professor of Medicine & Chairman, Department of Medicine, Jefferson Medical College, Thomas Jefferson University, Philadelphia, Pennsylvania (Formerly at Johns Hopkins).
- Eugene S. Sullivan, M.D. - Clinical Associate Professor of Surgery, University of Oregon Medical School, President, American Society of Colon & Rectal Surgeons, Portland, Oregon.
- John H. Yardley, M.D. - Professor of Pathology, Department of Pathology, The Johns Hopkins University, School of Medicine, Baltimore, Maryland.

A block of rooms has been reserved at the Birmingham Hilton for the meeting. The fee for the seminar is \$40, which includes lunch. For further information and to register, contact: Mrs. Dena Metts, Medical Staff Coordinator, South Highlands Hospital, 1127 South 12th Street, Birmingham, Alabama 35205. **Phone: (205) 250-7703.**

*October 14th is the day prior to the Alabama/Tennessee football game.

PANELISTS

- Arthur M. Freeman, M.D. - (Moderator), Director of Medicine-South Highlands Hospital, Clinical Professor of Medicine, The Univ. of Alabama School of Medicine, (Gastroenterology), Birmingham, AL
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The President Speaking

Mathematics of Medicare Discrimination

Whitman B. Johnson, Jr., M.D.
Clarksdale, Mississippi

Discrimination is a double-edged, double-meaning, emotion-evoking word that dominates our daily lives, particularly in the South. It means both the action of making fine distinctions, then moving accordingly, as well as acting on prejudice without other concern. As we are told by federal law, there are two types of discrimination: *de facto* (because of the facts) and *de jure* (because of the law). Of these *de jure* is the worse of the sins.

Of course, some kinds of discrimination are not only desirable, but are necessary. Otherwise, we would be drinking sulfuric acid for water, and eating toadstools for mushrooms and poison ivy for spinach. But using discrimination by acting on prejudice without considering the consequences to others or the long-term effects on society as a whole is foolish as well as self-defeating. This makes one wonder why the federal government, in its wisdom, is in effect practicing *de jure* discrimination against the people of Mississippi and its Medicare laws and policies.

Every Medicare recipient in the United States pays the same monthly fee for part B coverage, yet the money returned to them to cover the costs of their medical care varies widely. A complete initial office exam including EKG, chest x-ray, CBC, and routine urinalysis is covered by as much as \$155.96 in California, \$145.00 in Illinois, \$146.90 in New York, \$105.00 in Minnesota, \$160.20 in Alaska, \$177.50 in Pennsylvania, \$114.40 in Texas, and \$61.60 in rural Mississippi. Medicare allows \$600.00 for transurethral resection of the prostate in Mississippi, while in California \$1,458.57 is returned. A hip should be broken in New York, where the patient recovers \$1,853.00, instead of Jackson, Mississippi, where the patient receives \$648.50. A hemorrhoidectomy patient in Clarksdale is allowed \$225.00 while his family in Illinois is covered to \$427.80. For the implantation of a pacemaker in Tupelo or Meridian a patient recovers \$713.00, while in Washington, DC, a patient gets back \$1,069.50 — but everyone knows how big hearted those bureaucrats are. A radical mastectomy in Hattiesburg is worth \$570.40 to the recipient, but in Dallas she can recover \$1,000.00. A cataract removed on the Gulf Coast returns \$570.40, while in the Los Angeles area, the price is \$1,263.92. Of course, there might be more to see in Hollywood than there is Biloxi unless the Miss U.S.A. pageant returns. These

(continued on page 243)

Send Us Your Comments

This is a hell of a time to have to meet a deadline. It's hot and the dog-days are upon us, plus, some of us are trying to get caught up after summer vacation and trying to again adjust to this life of constant interruption. I was brought up by a patient the other day whose pelvic exam was interrupted by a long distance call about which I came back from bitching. She informed me that when I should start worrying was when that phone *stopped* ringing! Of course, she was so right.

I can go on — the vacuous promises spewed indiscriminately on us by the desperate political hopefuls; injuries besetting the Rebels already; the hospital in the midst of a long-needed remodeling — jackhammers, dust, and disruption.

I realize that most of my contributions to this page have been airings of my many personal gripes, but in view of the few listed above, it's pretty hard to get inspirational about anything! I almost said "at this point in time!" Another gripe!

Those of us in the northern portion of the state in the purview of the *Commercial Appeal* have been offered a series of well-researched articles (the 13th, today) on the rising costs of medical care from every angle: ours (they place the greatest onus on us!); the hospitals, which also have their share of onuses (OK, is it oni?); the insurance companies; the Feds; and finally, the patients! Somewhere, someplace, it must stop, and it will take concerted efforts by us, third parties, the government *and* the patients.

Have you any ideas? If so, send them in to "Comment" here in the JOURNAL MSMA. It's got to start somewhere, and what's better than the "grass-roots?"

The small incursions so far of socialized medicine are, I fear, only the tip of the iceberg.

ARTHUR A. DERRICK, JR., M.D.
Associate Editor

Mathematics of Medicare Discrimination

(continued from page 242)

figures are not exact since they were published in 1979; but if anything, the spread is greater due to the application of the "Economic Index" over the past four years.

To put this in a different perspective: every Medicare recipient pays \$12.20 per month for part B coverage. If the average return in the United States were 100%, then the patients in New York and Alaska get back 132%; Nevada, 125%; California, 120%; District of Columbia, 116%; and Florida, 112% — to name a few. Our Mississippians are returned 73% of the national average. It would seem only fair that they pay 73% of \$12.20 if there were no discrimination.

We as physicians should not feel paranoid about this situation because we are not required to accept Medicare assigned benefits, but our patients are locked into these payments by law. This has the effect of having made them subsidize payments in every other state in the union for their "medical insurance" since enactment of the law in 1965. That adds up to a lot of money that has left our economy to support medical care in the rest of the country. In addition to this, these people do not know it is happening to them. They are continually told that all doctors charge too much, when actually, Mississippi physicians have partially caused this "subsidize the rich" problem, by holding prices down in the past.

If this doesn't add up to discrimination *de jure* toward the people of Mississippi, then I don't know any mathematics.

Do you get the idea that when the judges decree that discrimination is illegal, that they mean for us in Mississippi to eat toadstools and poison ivy and drink sulfuric acid while the rest of the nation has mushrooms, spinach, and pure water? ★★★

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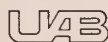
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MIST—Medical Information Service via Telephone—is a rapid access toll-free line for physician to physician consultations. Faculty specialists from the University of Alabama in Birmingham Medical Center are ready to discuss patient care with you 24 hours a day, 7 days a week. And there's never a charge for professional consultations.

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Awake with allergies

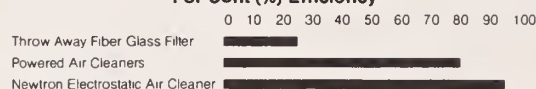


You feel for them... your patients, young and old, who suffer from symptoms of airborne allergies.

Until now, there has not been an effective and economical method to remove these pollutants from the air. Disposable air filters are quite inexpensive...but ineffective. Powered electronic and pleated paper air cleaners are more effective...but very expensive. But now there is an air cleaner that cleans better than any other competitive air cleaner on the market regardless of cost...and we cost less.

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Disposable filters remove only 20% of airborne pollutants. Expensive powered electronic air cleaners have an effectiveness that ranges from 50% to 85%. But the Newtron® Electrostatic Air Cleaner is the most effective of all. The Newtron® will remove 96% of the pollen, dust and tobacco smoke from your patient's home or business.

The Newtron® develops its internal static charge simply by air flowing through grids and collecting rods made of static prone materials. Smoke, pollen and dust are trapped and held in the electrostatically charged media. A periodic rinsing with tap water cancels the internal static charge and flushes out the trapped pollutants.

The Newtron® comes in standard filter sizes making it easy for your patient to simply remove the old disposable filter and slip in a Newtron®. There is no expensive installation or maintenance and no ozone emission.

The Newtron® has a full five year warranty but should last indefinitely since there are no electronics or moving parts.

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NEW MEMBERS

ALLEN, JAMES M., Philadelphia. Born Columbus, OH, Nov. 14, 1944; M.D., University of Alabama School of Medicine, Birmingham, 1980; interned Baptist Hospitals, Birmingham, one year; elected by East Mississippi Medical Society.

BALL, ALBERT LUTHER, Biloxi. Born Manila, Philippines, July 29, 1939; M.D., Medical College of Wisconsin, Milwaukee, 1965; interned L. A. County General Hospital, Los Angeles, one year; pediatric residency, University of Oregon Medical School Hospital and Clinic, Portland, 1968-70; elected by Coast Counties Medical Society.

DIAL, JOHN D., Tunica. Born Pilot Point, TX, Jan. 12, 1934; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned University Medical Center, Jackson, MS, one year; elected by Clarksdale and Six Counties Medical Society.

FITE, JAMES W., Grenada. Born Grenada, July 10, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned and pediatric residency, University Medical Center, Jackson, MS, 1974-77; elected by North Central Medical Society.

GADDY, IRA EUGENE, III, Gulfport. Born Monroe, LA, Sept. 1, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned Baptist Memorial Hospital, Memphis, TN, one year; ophthalmology residency, University Medical Center, Jackson, MS, 1980-83; elected by Coast Counties Medical Society.

McGEE, HILDA JANE, Hattiesburg. Born Union, MS, May 5, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1977; interned and ob-gyn residency, University of Louisville Affiliated Hospitals, Louisville, KY, 1977-82; elected by South Mississippi Medical Society.

PURDON, JAMES S., Oxford. Born Pontotoc, MS, Dec. 16, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned Baptist Memorial Hospital, Memphis, TN, one year, elected by North Mississippi Medical Society.

QUINIF, ALICE M., Greenville. Born Athens, GA, Jan. 17, 1955; M.D., Medical College of Georgia, Augusta, 1979; interned and radiology residency, Akron General Medical Center, Akron, OH, 1979-83; elected by Delta Medical Society.

Anxious patients improve in just a few days

And what is more reassuring to an excessively anxious patient than medication that promptly starts to relieve his discomforting symptoms? Valium® (diazepam/Roche) begins working within 30 to 90 minutes. Patients continue to improve in just a few days, and relief continues throughout the course of treatment.

There are other important benefits with Valium as well—along with its broad clinical range, Valium has an efficacy/safety profile that few, if any, drugs can match. This record has been achieved with extensive clinical experience, undoubtedly including yours. And, as you must have observed, side effects more serious than drowsiness, fatigue or ataxia rarely occur. Nevertheless, as with any CNS-acting agent, patients should be cautioned about driving, operating hazardous machinery or ingesting alcohol or other CNS-depressant drugs while taking Valium.

Yet another benefit Valium affords is flexibility.






Available in 2-mg, 5-mg and 10-mg scored tablets, Valium enables you to titrate dosage to individual patient needs. For the geriatric patient, a starting dosage of 2 to 2½ mg once or twice a day is recommended. And, for patients who forget or skip medication, you can prescribe Valrelease™ (diazepam/Roche) 15-mg slow-release capsules,

knowing that Valrelease will assure all the benefits of Valium 5 mg *t.i.d.* with the convenience of once-a-day dosage.

Discontinuation of Valium (or Valrelease) is typically as smooth as its start in short-term therapy. However, Valium and Valrelease should be discontinued gradually after more extended treatment. As you diminish dosage, the built-in tapering action of Valium and Valrelease will help avoid rapidly recurring anxiety symptoms and symptoms of withdrawal, and will help ease the patient's transition to independent coping when therapeutic goals have been achieved.

...that's one of
the unique benefits of
Valium®
diazepam/Roche

Valium® (diazepam/Roche)  Tablets
Valrelease™ (diazepam/Roche)  slow-release Capsules
Injectable Valium® (diazepam/Roche) 

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. **Oral forms** may be used adjunctively in convulsive disorders, but not as sole therapy. **Injectable form** may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Use in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL. Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE. *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used IV: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly IV, it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3; administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over sedation (initially 2 to 2½ mg once or twice daily; increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE. Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity,

insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE. Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL. Adults: Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) **tablets**, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—**tablets**, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—**tablets**, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—**tablets**, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: **Tablets**—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). **Capsules**—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: **Tablets**—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). **Capsules**—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE. Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.) For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly; take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children administer I.V. slowly; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, IV fluids, adequate airway. Use levorotatory or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL. Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Ject® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.



PERSONALS

ORLANDO ANDY of UMC spoke at a joint meeting of the International Society of Psychiatric Surgery and World Congress of Psychiatry in Vienna, Austria, in July.

JIM C. BARNETT of Brookhaven has been recertified by the American Academy of Family Physicians.

BRYAN BARKSDALE of Jackson was appointed by Gov. William Winter to a three-year term on the Governor's Council on Physical Fitness and Sports.

W. JOSEPH BURNETT of Oxford announces the association of ROY S. GOODMAN in practice at the North Mississippi Ear, Nose and Throat Surgical Clinic.

RON CANNON of Brandon was appointed by Gov. William Winter to a three-year term on the Governor's Council on Physical Fitness and Sports.

WILLIAM H. CLELAND has associated with Jackson Clinic for Women, P.A., for the practice of obstetrics and gynecology.

CLINTON M. CAVETT announces the opening of his office for the practice of pediatric surgery at Suite 201, Medical Arts Building, in Jackson.

WILLIAM W. EAST of Meridian announces the association of T. KEITH EVERETT for the practice of ophthalmology.

JACK C. EVANS has associated with the Laurel Family Clinic in the practice of family medicine.

JACK B. FOSTER has associated with Internal Medicine Associates of Tupelo, Ltd., for the practice of cardiology.

ALAN FREELAND and JOHN PURVIS of Jackson were elected president and secretary of the Jackson chapter, Miss. Orthopedic Society.

RICHARD L. GEORGE of Columbus has been recertified by the American Academy of Family Physicians.

EDWARD J. HILL of Hollandale has been recertified by the American Academy of Family Physicians.

VICTOR HORN announces the opening of his office for the practice of family medicine at Doctors Park in Houston.

G. ELI HOWELL, II, announces the opening of his office for the practice of plastic surgery at 710 South 28th Avenue in Hattiesburg.

C. NOLEN HUDSON has associated with The Street Clinic of Vicksburg for the practice of surgery.

JOHN H. JAMES of Petal announces the association of JOHN M. BEAMAN for the practice of family medicine at 611 S. Main Street.

DANIEL W. JONES of Laurel announces the association of THOMAS K. JUDD for the practice of gastroenterology at the Internal Medicine Clinic of Laurel, P.A.

E. L. LAIRD of Union recently was honored with a reception in recognition of his fifty years of active practice.

JOSEPH E. JOHNSTON of Mt. Olive has been recertified by the American Academy of Family Physicians.

BRYAN F. MCCRAW and TIMOTHY M. WRIGHT announce the opening of the Internal Medicine Clinic of Columbia.

HUGHES MILAM has associated with the Urology Professional Association, 605 Garfield Street, Tupelo, for the practice of urology.

RAY E. MYATT has associated with Rush Medical Group, 1314 19th Avenue in Meridian, for the practice of obstetrics and gynecology.

FRANCIS MORRISON of UMC attended a board of directors meeting of the South Central Association of Blood Banks in Austin, Texas, recently.

C. G. NICHOLS of Leland has been recertified by the American Academy of Family Physicians.

GUY L. ODOM announces the opening of his office for the practice of general surgery at 798 Dunbar Avenue in Bay St. Louis.

Gamble Brothers and Archer Clinic of Greenville announces the association of NICHOLAS J. QUINIF for the practice of urology.

ERNEST P. REEVES of Collins has been recertified by the American Academy of Family Physicians.

R. DWAIN REEVES announces the opening of his office for the practice of internal medicine at 348 Crossgates Boulevard in Brandon.

WILLIAM H. ROSENBLATT of Jackson announces the association of THOMAS A. THOMPSON for the practice of cardiology.

ROBERT SCHNEIDER has associated with Emergency Physicians of Hattiesburg.

CHRIS J. SEARCY has associated with Columbus Women's Clinic for the practice of obstetrics and gynecology.

HILDON H. SESSUMS, JR. has associated with the Family Medicine Clinic, 1907 Mission 66, in Vicksburg, for the practice of family medicine.

JULIA ANN SHERWOOD has joined the Children's Clinic of Jackson for the practice of pediatrics.

SYDNEY A. SMITH announces the opening of his office for the practice of neurology at 1500 45th Avenue in Gulfport.

DAVID R. STECKLER of Natchez announces the association of JAMES I. CLARK for the practice of anatomical and clinical pathology.

JERRY L. STENNETT announces the opening of his office for the practice of general, thoracic and vascular surgery at 330 North Broad Street in Forest.

JAMES E. STRONG, JR. of Jackson has been named a fellow to the American College of Physicians.

Tupelo Orthopaedic Clinic, P.A., 450 Gookin Boulevard, announces the association of JOHN A. TANKSLEY for the practice of orthopaedic surgery.

GERI L. WEILAND has joined The Street Clinic of Vicksburg for the practice of pediatrics.

HENRY E. WOOD announces the opening of his practice of internal medicine at 405 Security Square in Gulfport.

JOHN D. WOFFORD, JR. of Jackson announces the opening of his office for the practice of infectious diseases and internal medicine at 768 Lakeland Drive.

RALPH EDWARD WILLIAMS has joined the Rush Medical Group of Meridian for the practice of radiology.

DEATHS

ABIDE, JOHN K., Cleveland. Born in Greenwood, MS, Dec. 7, 1936; M.D., Tulane University School of Medicine, New Orleans, 1961; interned and ob-gyn residency, Charity Hospital, New Orleans, 1961-65; member of Delta Medical Society; died July 14, 1983, age 46.

Medico-Legal Brief

MD Loses Antitrust Suit Against Hospital, Physicians

A hospital and four physicians were entitled to summary judgment in an antitrust action against them by a physician who was not reappointed to the hospital staff, a federal trial court in Pennsylvania ruled.

The physician was a pediatric and thoracic cardiovascular surgeon. He graduated from medical school in 1947, and was the author of 33 publications. Besides having conducted 35 presentations at various seminars and professional meetings, he was the author, co-author, and producer of 12 motion pictures dealing with various adult and pediatric cardiovascular surgical topics. In 1957, he was hired to do cardiac surgery on a full time basis at the hospital.

Three years later he terminated his employment with the hospital and entered private practice. About ten years later the physician began to make allegations of improper referrals of surgical patients by cardiologists at the hospital. The medical director investigated the allegations, found them lacking, and wrote the surgeon to that effect. The physician remained dissatisfied with the referral practices and on one occasion attempted to persuade the parents of a patient to use him to operate instead of the physician they had selected.

In 1975, the credentials committee unanimously recommended that he not be reappointed. The charges against the physician included: (1) incompetence; (2) excess mortality rate among his patients; (3) unnecessary operations; (4) failure to adhere to standard medical practices; (5) failure to adhere to the established teaching practices of the hospital; (6) unprofessional conduct with patients; (7) inability to cooperate with other surgeons and staff members; and (8) insufficient recent surgical experience.

After a hearing which more than adequately afforded the physician due process, the decision was affirmed. He then filed an antitrust suit against the hospital and four physicians. He alleged that they had conspired to boycott his surgical practice and restrain trade and competition among physicians. The court applied the rule of reason to the antitrust claims and said that the decision not to reappoint him to the staff was based on valid reasons supported by evidence. The court held that the essential facility

(continued on page 253)

MEDICAL ORGANIZATION

MSMA Board of Trustees Holds Summer Meeting

Officers and members of MSMA's Board of Trustees held their regular summer meeting in Oxford on August 4 and handled a busy agenda.

Among matters coming before the Board were referrals from the recent meeting of the MSMA House of Delegates and reports dealing with such diverse subjects as guidelines for breast cancer treatment, representation on hospital governing boards, chemicals in food, air and water, health services provided by the State Department of Health, medical licensure by reciprocity, co-payments on Medicaid services, definition of hospital medical privileges, use of marijuana by minors and patient medication instructions.

The Board heard a status report on organization of MSMA Services, Inc. and the MSMA Benefit Plan and Trust. Both programs were on schedule with respect to their implementation and the Board acted to appoint a Benefits Committee to oversee administration of the latter.

The Board reviewed an MSMA reorganization plan which the House of Delegates had considered. The plan will again be before the House for final action at the 1984 Annual Session.

Based on action by the Board, the 1984 MSMA Health Issues Seminar will be held in Jackson on March 3-4. The program will be devoted to the subject of hospital-medical staff relationships and will include papers on DRG reimbursement, competition and hospital staff privileges.

The Board examined the issues surrounding so-called emergency medical clinics and will monitor the feasibility of establishing minimal criteria for such clinics.

The Board received a report from the Mississippi Medical Political Action Committee concerning that organization's participation in elections for the Mississippi Legislature. It was noted that 71 percent of MMPAC-supported candidates had won in first primary elections.

In other actions the Board will study a report concerning AMA endorsement of indemnity reimbursement for physician services in lieu of reimbursement by usual, customary and reasonable fee determination. The Board will also study the feasibility of the association's serving as state distributor for the AMA/GTE network.

In attendance at the Board meeting were: Drs. J. O. Manning, Jackson, chairman; W. Joseph Burnett, Oxford, vice chairman; Roy D. Duncan, Pascagoula, secretary; Virginia S. Tolbert, Ruleville; William C. Gates, Columbus; William B. Hunt, Grenada; C. G. Sutherland, Jackson; George L. Arrington, Meridian; W. Boyce White, Laurel; David R. Steckler, Natchez; Whitman B. Johnson, Jr., Clarksdale, president; Ellis M. Moffitt, Jackson, president-elect; Sidney O. Graves, Jr., Natchez, immediate past president; Carl G. Evers, Jackson, speaker of the House; James C. Waites, Laurel, vice speaker of the House; James O. Gilmore, Oxford, delegate to AMA; and W. Lamar Weems, Jackson, delegate to AMA.

Biloxi Will Host Hypertension Conference

The senior medical consultant to the National Heart, Lung, and Blood Institute's High Blood Pressure Education Program headlines the list of physicians who will serve on the faculty for the Ninth Annual Southeastern High Blood Pressure Conference October 5, 6, and 7 at Biloxi.

Marvin Moser, M.D., will deliver the conference keynote address. Clinical professor of medicine at New York Medical College, he served as chairman of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure in 1976 and as vice chairman in 1980. He is attending physician in medicine and physician in charge of the hypertension clinic at Westchester County Medical Center, Valhalla, New York, and emeritus chief of cardiology at White Plains Hospital Medical Center, White Plains, New York.

Other physicians who will explore "Controversies and New Approaches to the Management of High Blood Pressure" — theme of the three-day meeting — include Jerome D. Cohen, J. Morley Kotchen, and Albert Oberman.

Dr. Cohen is associate professor of internal medicine at the St. Louis University School of Medicine, St. Louis, Missouri. He will lecture on "Total Cardiovascular Risk Management."

Associate professor of medicine at the University of Kentucky, Lexington, Dr. Kotchen will discuss "Youth and High Blood Pressure." She was formerly acting director of Research Design Biostatistics Laboratory at Albert Chandler Medical Center

in Lexington.

Dr. Oberman, professor of preventive medicine and chairman of the department and professor of public health at the University of Alabama in Birmingham, will present two lectures on October 7. He'll discuss "The Role of Newer Agents in Hypertension Control" and "Important Antihypertensive Agent Interactions with Other Drugs."

In a special seminar session on the conference's second day, physicians will discuss controversies in the treatment of mild hypertension, including conflicting data from the Hypertension Detection and Follow-up Program (HDFP) and Multiple Risk Factor Intervention Trial (MRFIT). Dr. Oberman, with assistance from Dr. Moser, will cover the HDFP, and Dr. Cohen will present MRFIT data.

Conference sponsors include the Mississippi State Department of Health, American Heart Association — Mississippi Affiliate, Kidney Foundation of Mississippi, Mississippi Nurses Association, National High Blood Pressure Education Program, and the University of Mississippi Medical Center Division of Continuing Health Professional Education.

The UM School of Medicine has designated this continuing education activity for credit in Category 1 of the Physicians Recognition Award of the American Medical Association.

Registration with name, address, and Social Security and telephone numbers should be mailed to High Blood Pressure Conference, State Department of Health, P. O. Box 1700, Jackson, MS 39205. Checks for \$35 registration fee should be made payable to Southeastern HBP Conference.

Additional information is available by contacting the Hypertension Program at the State Department of Health, telephone 961-4088.

UMC Offers Workshop On Extremity and Spinal Joints

The University of Mississippi Medical Center will host a workshop on extremity and spinal joint manual therapy October 5-9 at the Holiday Inn Downtown in Jackson.

Sponsors of the course are the UMC School of Health Related Professions, School of Medicine Department of Surgery (orthopedics), University Hospital Department of Physical Therapy and the UMC Division of Continuing Health Professional Education. Cosponsor is the Mississippi chapter of the American Physical Therapists' Association. Course coordinators are Cathy Hansen, B.S., R.P.T., clinical instructor in physical therapy, and Brooke Mueller, M.Ed., R.P.T., UMC assistant professor of physical therapy.

This workshop introduces the basic concepts of joint mobilization and offers detailed study of the anatomy and biomechanics of extremity and spinal joints. Extensive laboratory practice will cover clinical examination and treatment techniques. Presentations include adjunctive treatment, traumatology, pathology, pathophysiology of pain and applied kinesiology.

Guest lecturer is Michael D. Rogers, R.P.T., M.N.F.F., certified manual therapy specialist in peripheral and spinal joint mobilization. Rogers is a graduate of the SUNY-Buffalo physical therapy program and took postgraduate training in manual therapy under Ola Grimsby at Sørlandets Fysikalske Institute in Vagsbygd, Norway. He also studied under Cyriat and Mennell and trained in muscle energy techniques at Michigan State University School of Osteopathic Medicine. Rogers is director of Gulf Coast Physical Therapy Group, P.A.

Fee for the four-and-a-half day course is \$280. Credit will be determined. Registration is limited to 30 participants, so early registration is advised.

MS Society Honors UMC Neurologist



Anne Plummer, executive director of Multiple Sclerosis of Mississippi, presents a plaque of appreciation to Dr. Robert D. Currier, professor of neurology and chairman of the department at the University of Mississippi Medical Center. The plaque cites Dr. Currier's outstanding contributions to multiple sclerosis research as well as his dedication to treatment programs.

In vitro studies demonstrate

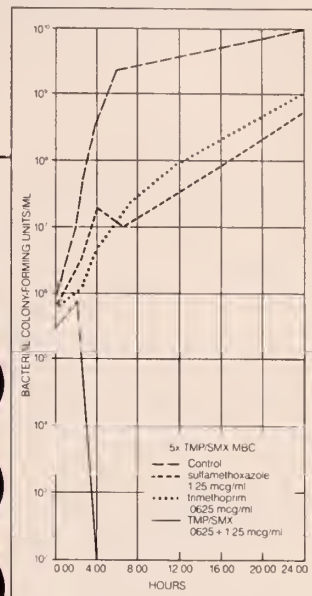
ROCHE

Bactericidal activity

with minimal resistance

RAPID IN VITRO DESTRUCTION OF *E. COLI* *

Percent of isolates of common uropathogens sensitive to BACTRIM and to other antimicrobials



Kill curve kinetics of Bactrim and its individual components against *E. coli* *in vitro*.¹

[†]Analogous to cephalothin, the primary antibiotic disc used in testing.

Source: The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter Series, 1981-82. Numbers under percentages refer to the projected number of isolates tested.

The bactericidal action of Bactrim has been demonstrated *in vitro* on laboratory strains of *E. coli*^{1,2} and on clinical isolates of *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and *Morganella morganii*³—the most common causative organisms of urinary tract infections.⁴ More than 100 published studies attest to the efficacy of Bactrim in recurrent urinary tract infections due to these organisms.⁵ In comparative studies with other antimicrobials, Bactrim has consistently demonstrated unsurpassed efficacy during therapy.^{6,11}

Resistance to Bactrim develops more slowly than to either of its components alone *in vitro*.^{*} Among urinary tract isolates, resistance has rarely emerged in susceptible strains.^{5,12} Bactrim is contraindicated in pregnancy at term, during lactation, in infants less than two months old and in documented megaloblastic anemia due to folate deficiency. Initial episodes of uncomplicated urinary infections should be treated with a single-agent antimicrobial.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

b.i.d. for recurrent urinary tract infections

^{*}*In vitro* data do not necessarily predict clinical results.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kramer MJ, Mauriz YR, Robertson TL, Timmes MD. Morphological studies on the effect of subinhibitory and inhibitory doses of sulfamethoxazole-trimethoprim combination on *Escherichia coli*. Presented at the 12th International Congress of Chemotherapy, Florence, Italy, July 19-24, 1981. 3. Spicehandler J et al. *Rev Infect Dis* 4:562-565, Mar-Apr 1982. 4. Stamey TA. Pathogenesis and Treatment of Urinary Tract Infections. Baltimore, Williams & Wilkins, 1980, p. 13. 5. Ronald AR. *Clin Ther* 3:176-189, Mar 1980. 6. Cooper J, Brumitt W, Hamilton M, Miller JMT. *J Antimicrob Chemother* 6:231-239, 1980. 7. Gower PE, Tasker PRW. *Br Med J* 1:684-686, Mar 20, 1976. 8. Cosgrove MD, Morrow JW. *J Urol* 111:670-672, May 1974. 9. Irvani A et al. *Antimicrob Agents Chemother* 19:598-604, Apr 1981. 10. Schaeffer AJ, Flynn S, Jones J. *J Urol* 125:825-827, Jun 1981. 11. Rous SN. *J Urol* 125:228-229, Feb 1981. 12. BAC-DATA Medical Information Systems, Inc., Bacteriologic Reports, Winter Series, 1976-82.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term, nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients. **Pregnancy:** Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folate metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml), cherry flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per tea spoonful (5 ml), fruit-licorice flavored—bottles of 16 oz (1 pint).

References:

- Stone PH, Turin ZG, Muller JE. Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104:672-681, September 1982.
- Antman E, Muller J, Goldberg S, et al. Nifedipine therapy for coronary-artery spasm. Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 1980.

BRIEF SUMMARY

PROCARDIA® (nifedipine) CAPSULES

For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g. where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl may be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates. PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients; transient hypotension in about 5%, palpitation in about 2%, and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antihypertensive medication. Additionally the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NOC 0069-2600-66), 300 (NOC 0069-2600-72), and unit dose (10x10) (NOC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59 to 77 F (15 to 25 C) in the manufacturer's original container.

More detailed professional information available on request.

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ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



LABORATORIES DIVISION
PFIZER INC.

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



*"My daily routine consisted of
sitting in my chair trying to stay alive."*

*"My doctor switched me to
PROCARDIA[*] as soon as it became
available. The change in my condition
is remarkable."*

*"I shop, cook and can plant
flowers again."*

*"I have been able to do volunteer
work...and feel needed and useful
once again."*

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,¹ taking fewer nitroglycerin tablets,² doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

* Procordia is indicated for the management of:

- 1) Confirmed vasospastic angina.
- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

PROCARDIA[®] **(NIFEDIPINE)** Capsules 10 mg

Please see PROCARDIA brief summary on adjoining page.

Motrin[®]

ibuprofen, Upjohn

600 mg Tablets



More convenient for your patients

Upjohn



Dr. Frank Elgin (third left) is the recipient of the fifth annual Jaquith Award, presented by the Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center. Named in honor of William L. Jaquith, former director of the Mississippi State Hospital at Whitfield, the award is given each year to the most outstanding graduating senior resident in psychiatry. Sandoz Pharmaceuticals sponsors it. Dr. Elgin expects to

join the staff of the State Hospital September 1. With him are, left to right, Dr. Garfield Tourney, UMC professor of psychiatry and human behavior; Dr. Edgar Draper, professor and department chairman; James Stubbs, director of the State Hospital; and John M. Cole, medical services liaison associate, and Larry Pietzyk, senior technical representative, Sandoz Pharmaceuticals.

Dr. Lockey Will Address Communicative Disorders Symposium

The University of Mississippi Medical Center's fourth annual communicative disorders symposium takes place November 4 in Jackson.

Dr. Myron W. Lockey, Jackson otolaryngologist, will deliver the program's Godfrey Edward Arnold lecture in his description of current concepts in surgery for hearing loss. Also on tap are a survey of current topics in audiology and a panel discussion on aphasia.

Joining Dr. Lockey in the symposium are guest speakers Dr. Subhash Bhatnagar, associate professor of communicative disorders at the University of Mississippi in Oxford, and Dr. Keener D. McClelland, Hattiesburg audiologist. UMC faculty participating are Dr. Ojus Malphurs, Jr., assistant professor of surgery (otolaryngology) and director of the Communicative Disorders Laboratory; Dr. Stephen E. Nadeau, assistant professor of neurology; and Dr. Jeffery Webster, assistant professor of psychiatry and human behavior.

Coordinating the 1983 symposium is Judson Farmer, instructor in surgery (otolaryngology) and clinical supervisor of the Communicative Disorders Laboratory. Symposium sponsors are the UMC School of Medicine Department of Surgery Division

of Otolaryngology, the University Hospital Communicative Disorders Laboratory and the UMC Division of Continuing Health Professional Education.

Fee for the symposium is \$20. The American Medical Association will award 5 credit hours in Category 1 of the Physicians' Recognition Award. The program has been submitted for 5 hours of continuing education credit to the Mississippi Speech and Hearing Association committee on continuing education. The Medical Center Division of Continuing Health Professional Education will award .5 CEU for full attendance.

Further information may be obtained by contacting Continuing Education at the University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601) 987-4914.

Medico-Legal Brief

(continued from page 250)

argument made by the plaintiff was inapplicable in hospital staff privileges decisions.

The hospital's referral procedures were followed by the staff physicians and they did not constitute concerted action against the physician, the court said. It granted summary judgment in favor of the hospital and four physicians. — *Pontius v. Children's Hospital*, 552 F.Supp. 1352 (D.C., Pa., Dec. 30, 1982)

Roche salutes
the history of Mississippi medicine



SOLVING THE MYSTERY OF PASCAGOULA

More than 20 years ago, a combined demonstration of medical science and community effort turned an outbreak of infectious hepatitis in Mississippi into a national landmark of disease prevention.¹

When health officials in Pascagoula, Mississippi, reported more than a dozen cases of hepatitis, the Communicable Disease Center in Atlanta assigned an epidemiologist to aid local efforts in tracing the origin of the infection.

Nurses on duty at the Jackson County Health Clinic and physicians at Singing River Hospital were interviewed, as were the patients themselves. It soon became clear that the patients had not shared a meal, had not frequented the same restaurant and had not been together in any of the most likely sites for contamination. However, a startling fact did come to light... each of the 13 infected patients had eaten raw oysters within the previous two months.

Checking and double-checking the clues...

Raw oysters were a common food in Pascagoula, but at that time shellfish were not known to cause hepatitis. As a control, 13 names were selected from the city's

telephone book. Each person questioned denied having eaten oysters, and none had symptoms of hepatitis. The investigation was narrowing down, but there was still much probing to be done.

...to find the cause

With the assistance of a sanitation engineer and a shellfish expert, the investigators began the tedious task of inspecting the local stores, oyster plants, packagers and shucking companies. Finally, they found the source of the infections: an oyster bed at the mouth of the Pascagoula River, ordered closed to oystering some 30 years earlier because it was polluted.

The diligent work of 20 specialists—epidemiologists, virologists, bacteriologists, internists, pediatricians and public health officers—had led to an awareness of shellfish as potential hepatitis carriers, and to the need for closely regulating both shellfishing and water pollution protections. The work done in Pascagoula stands as a remarkable joint effort in the history of modern medicine in the United States.

Reference: 1. An era of specialists, chap. 5, in Lee RV, Eimerl S *et al*: *The Physician*. New York, Life Science Library, Time Inc., 1967, pp. 107-109



When the history reveals anxious depression...

For the estimated 70 percent of nonpsychotic depressed patients who are also anxious,¹ Limbitrol provides both amitriptyline, specific for symptoms of depression, and the effects of Librium® (chlordiazepoxide HCl), the tested and dependable anxiolytic. Limbitrol is, therefore, a better choice for these patients than dual agents that contain a phenothiazine, a class of antipsychotic drugs used infrequently in nonpsychotic patients.¹

62% of Overall Improvement...Within the First Week

Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.²

In another multicenter study,³ the following symptoms associated with anxious depression were significantly reduced during the first two weeks of therapy:

- ☐ Headache—79%
- ☐ Early insomnia—91%
- Middle insomnia—87%
- Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.³

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K. Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jorvik ME; New York, Appleton-Century-Crofts, 1977, p. 316. 2. Feighner JP et al: *Psychopharmacology* 61: 217-229, Mar 1979. 3. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

In moderate depression and anxiety

Limbitrol®^{IV}

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Please see summary of product information on following page.

LIMBITROL® TABLETS (Tranquilizer—Antidepressant)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100; Prescription Paks of 50.

UMC Announces 22 Faculty Appointments

The University of Mississippi Medical Center has added 22 to the School of Medicine and centerwide faculties for the coming academic session.

Dr. Norman C. Nelson, vice chancellor for health affairs and medical school dean, announced the appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

In the School of Medicine, Dr. Martin Lester Dalton, Jr., was named professor of surgery. Dr. Bryan Dean Cowan was appointed assistant professor of obstetrics and gynecology, Dr. Robert A. Vander Griend assistant professor of surgery (orthopedics) and Dr. Jefferson Allen Fletcher, Dr. Dave Alan Russell, and Dr. Victor Eugene Salter assistant professors of medicine. Dr. James Lamp-ton Burkhalter, Dr. John Joseph Connors III and Dr. Ronald Edwin Gray were appointed assistant professors of radiology. Dr. Michael Lee Ard and Dr. Judith Karen Gore were named instructors in family medicine.

Appointed instructors in medicine were Dr. Andrew Spencer Anfanger, Dr. Charles Dale Cannon, Jr., Dr. L. C. Tennin, Jr., Dr. Indira Kota Veerisetty and Dr. John James White. Dr. Hannah Dee Berry Gay and Dr. Deborah Kay Hall were appointed instructors in pediatrics, Connie M. Anderson instructor in psychiatry and human behavior (social work) and Dr. Maxine Eakins instructor in surgery (urology).

New centerwide appointments included Dr. Andre J. Premen, instructor in microbiology.

Dr. Dalton is a graduate of the University of Alabama School of Medicine. He took surgical residencies at Mississippi Medical Center and was an instructor in surgery there for a year. He then served two years as chief of thoracic surgery at Walter Reed Army Institute of Research in Washington, D. C. He has since been in private practice in Lubbock, Texas.

Dr. Cowan earned the M.D. at the University of Colorado School of Medicine. He took postgraduate training at Portsmouth Naval Hospital and at the National Institute of Child Health and Human Development of the National Institutes of Health. He has been director of reproductive endocrinology, obstetrics and gynecology at the National Naval Medical Center in Bethesda, Maryland, since 1981.

Dr. Vander Griend earned the B.S. degree at Davidson College and received the M.D. from the University of Florida. He took his internship and residency in orthopedic surgery there.



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Dr. Fletcher received the B.S. from the University of North Alabama and earned the M.D. at UMC. Ole Miss alumnus Dr. Russell also earned the M.D. at UMC and served in the U. S. Army for two years before assuming his current appointment. Both physicians took their internships and residencies at the Medical Center and have held fellowships in cardiology there since July 1981.

Dr. Salter took his premedical studies at Ole Miss and earned the M.D. degree at UMC. He took his internship at Baroness Erlanger Hospital at the University of Tennessee Educational Center and then returned to UMC for his residency and a fellowship in pulmonary diseases.

Dr. Burkhalter and Dr. Gray received the M.D. degree from UMC, and both recently completed residencies in radiology there. Dr. Burkhalter is an alumnus of Ole Miss., while Dr. Gray attended Millsaps College.

Dr. Connors, who received his undergraduate degree from Vanderbilt, earned the M.D. degree at UMC, where he took residencies in both psychiatry and radiology. Prior to taking his residency in radiology, Dr. Connors was a consultant for the Mental Health Center in Brandon for two years.

Dr. Ard earned the B.S. degree at Mississippi State University and the M.D. degree at UMC, where he has been a resident in family medicine since July 1980. Dr. Gore, a graduate of Mississippi College, earned the M.D. degree from UMC and took her residency there.

Dr. Anfanger earned the B.A. degree from Oakland University and the M.D. at the Medical Center. He was a research assistant at Mount Sinai Hospital in New York for two years prior to his medical studies. Dr. Cannon, an Ole Miss alumnus, and Dr. White, an alumnus of the University of Southern Mississippi, earned the M.D. degree at UMC. Dr. Tennin, who received the B.A. from Gustavus Adolphus College, earned the M.D. from the University of Minnesota College of Medicine. All took their internships and residencies at the Medical Center. Dr. Veerisetty received the B.Sc. from Andhra Christian College and the M.B. and B.S. from Government Medical College where she also took her internship. She was a physician for the Social Security Disability Determination Unit in Jackson prior to taking her residency at the Medical Center.

Dr. Gay is an alumna of Ole Miss and Dr. Hall of Millsaps. Both earned the M.D. at UMC, where they have been residents in pediatrics for three years.

Ms. Anderson received the B.S. degree from Mississippi State and the M.S.W. from the University of Southern Mississippi. She has been a laboratory

technician in psychiatry at UMC since May. Ms. Anderson was a social worker for four years in Leflore County Public Welfare Department in Greenwood and the Tippah County Public Welfare Department in Ripley.

Dr. Eakins received the B.S. from Alcorn State University, the M.S. from Tuskegee Institute and the M.D. from the College of Human Medicine at Michigan State University. She took an internship in surgery at Ohio State University, as well as a residency in urology and general surgery. She has been a resident at Columbus Children's Hospital there since July 1980. Dr. Eakins also taught biology in Prentiss for two years.

Dr. Premen earned the B.S. at Baldwin-Wallace College and the Ph.D. at Uniformed Services University of the Health Sciences. He has been a postdoctoral fellow in physiology and biophysics at UMC since February. Dr. Staczek has been a research associate at UMC since 1979. His principal research interest is the herpes simplex virus. He earned the B.A. in biology at Saint Vincent College in Latrobe, Pennsylvania, and the Ph.D. at Rensselaer Polytechnic in Troy, New York. He also took postdoctoral training at the Wistar Institute of Anatomy and Biology in Philadelphia prior to his UMC appointment.

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IN CONCLUSION

Funding for Medicare and Medicaid tops a list of public policy issues ranked in order of importance by 133 health-related organizations, federal agencies, and congressional committees in a recent survey. National health insurance was the second highest concern. Other issues are health planning, preventive care, Medicare and Medicaid reimbursement for health personnel, biomedical research, National Institutes of Health funding, hospital cost containment, health education, health maintenance organizations, physician training and PSRO boards.

Patients whose kidney transplants are unsuccessful are not at increased risk when returned to hemodialysis, according to a study in the August 26 issue of JAMA. The study compared survival of patients returned to hemodialysis after losing a kidney transplant with the survival of patients undergoing maintenance dialysis. "Six-year actuarial survival of 83 patients after loss of a first transplant and of 37 patients after loss of two or more transplants compared favorably with data on survival of patients undergoing maintenance dialysis," the study said.

Children of alcoholic parents may face a genetically determined increase in their risk for developing alcoholism, according to a recent international study published in the August issue of Archives of General Psychiatry. Researchers found differences in brain wave responses between control subjects and the biological sons of alcoholic fathers after a single low dose of alcohol. Their data suggest that these children may be particularly sensitive to the effects of alcohol.

A group of Boston researchers has found evidence confirming that women who use intrauterine contraceptive devices are at greater risk for developing pelvic inflammatory disease, according to a report in the August 12 issue of JAMA. The study involved 460 premenopausal women using some form of contraception. The authors report that current IUD users were nine times more likely to contract pelvic inflammatory disease than were users of other contraceptive techniques.

The use of prophylactic antibiotics in surgery is "widespread and often inappropriate," according to one report published in the August 1983 issue of Archives of Surgery. The authors of the report conducted a literature review and concluded that while prophylactic antibiotics are indicated for a number of surgical procedures, "there are conflicting data on the usefulness of prophylaxis in abdominal hysterectomy, cesarean section, noncardiac thoracic procedures, and urologic surgery."

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References: 1. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 4. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 5. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Kales JD: *Pharmacol Physicians* 4:1-6, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5:25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The

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Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

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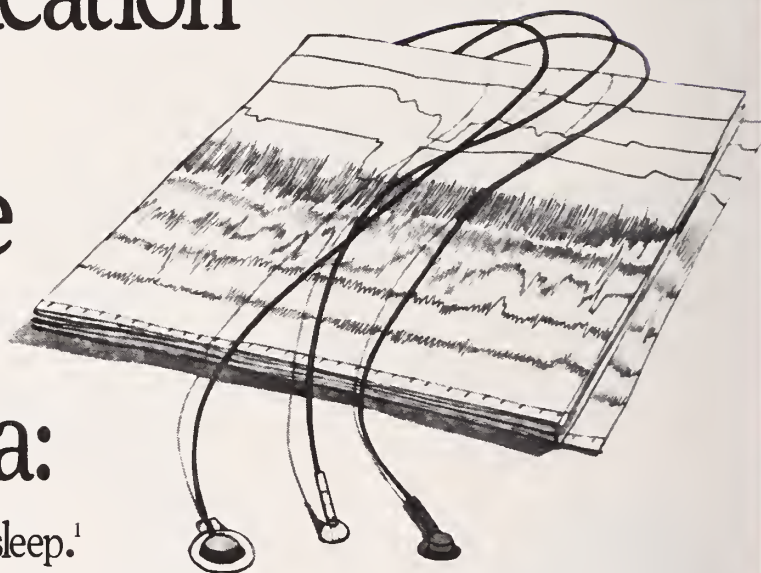
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DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 µg/ml and 0.09 µg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets. VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
December 1979

Committed to research...
because so much remains to be done.

Tableted by Janssen Pharmaceutica, Beerse, Belgium for



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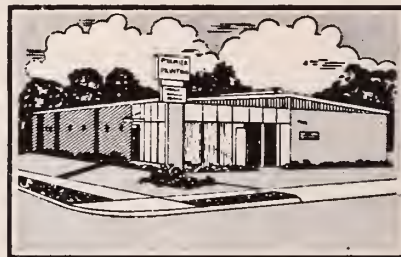


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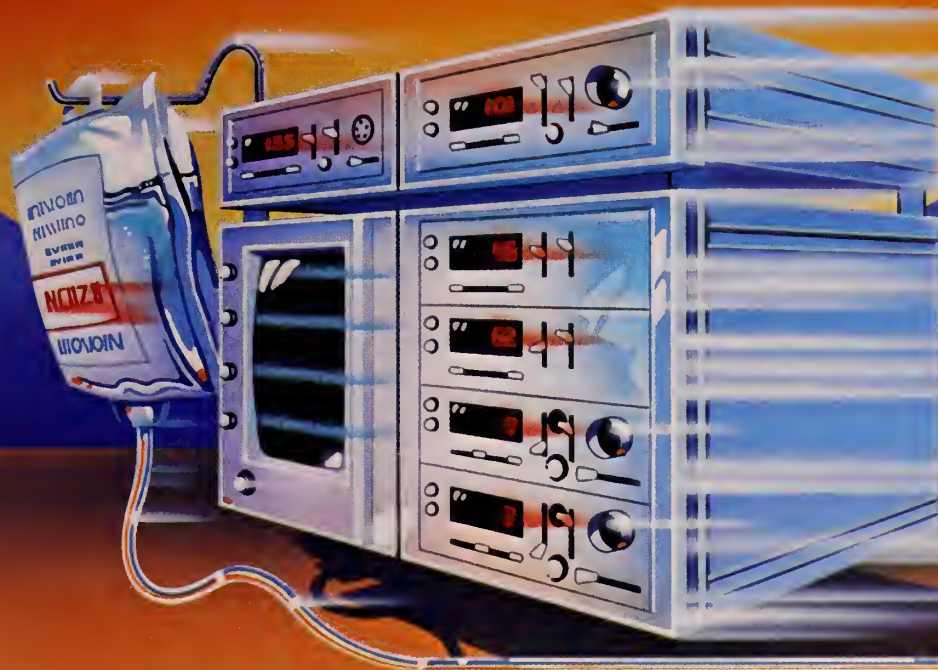
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NEWSLETTER

October 1983

Dear Doctor:

Is nutrition going to the dogs? Ask Ms. Sassafras Herbert. She recently was named a "Professional Member" of the American Association of Nutrition and Dietary Consultants, which describes itself as "a professional association dedicated to maintaining ethical standards in nutritional and dietary consulting." Sassafras is a poodle. Another applicant, Charlie the cat, became a professional member of the International Academy of Nutritional Consultants.

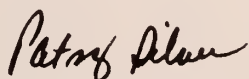
Dr. Victor Herbert, director of the Hematology and Nutrition Laboratory at the Bronx VA Medical Center in New York and owner of the animals, says the only requirement for many groups is paying a membership fee for the proposed member. The American Council on Science and Health released the story of Sassafras and Charlie in a public statement warning that it is difficult for consumers to distinguish well-qualified nutrition advisers from those with questionable credentials.

The new system of hospital reimbursement under Medicare, Diagnosis Related Groups (DRGs), went into effect this month. In a September conference, AMA Executive Vice President James H. Sammons, M.D. noted that the program marks a momentous change in the way government pays its share of medical and health care costs. He remarked that only physicians and hospitals are in a position to determine real patient needs, and said physicians must see that a hospitalized Medicare patient receives tests and procedures that he truly needs "regardless of whether a DRG does or does not apply."

U.S. Office of Technology Assessment has said it is "too early to consider DRGs the basis for all future changes in case-mix measurement." Among other things, the agency recommended that the effects of DRGs on quality and availability of care be monitored closely; that their long-term effects on hospital capital and teaching costs be studied; and that research on alternatives be continued.

MSMA members are invited to submit nominations for association offices. Elections to fill vacant posts will be held during the 116th Annual Session, May 16-20, 1984. The Sept. 15 issue of the "Blue Sheet" included a list of vacancies in offices and a statement of eligibility requirements. Nominations may be submitted to the MSMA headquarters or to members of the Nominating Committee.

Sincerely,



Patsy Silver
Managing Editor

MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 17-21, 1984, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

Mississippi State Medical Association, 116th Annual Session, May 16-20, 1984, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 13-17, 1984, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39221.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November, H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clark, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Richard C. Carter, Pres. and Secy., 314 W. Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. S. B. Fineberg, Sec'y., 2204 Old Mobile Hwy., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Pendergrass, Secy., 201 Hospital Dr., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly Mississippi State Medical Association 735 Riverside Drive Jackson, MS 39216	Northwest Mississippi Regional Medical Center Box 1218 Clarksdale, MS 38614
North Mississippi Medical Center 830 Gloster Avenue Tupelo, MS 38801	Mississippi Chapter American College of Surgeons Box 5229 Jackson, MS 39216
Forrest General Hospital Box 1897 Hattiesburg, MS 39401	Mercy Regional Medical Center 100 McAuley Drive Vicksburg, MS 39180
Mississippi Baptist Hospital 1225 N. State Street Jackson, MS 39201	North Panola County Hospital Drawer 160 Sardis, MS 38666
Gulf Coast Community Hospital 4642 W. Beach Boulevard Biloxi, MS 39531	Singing River Hospital 2809 Denny Avenue Pascagoula, MS 39567
Jefferson Davis Memorial Hospital Box 1488 Natchez, MS 39120	Magnolia Hospital Alcorn Drive Corinth, MS 38834
King's Daughter Hospital Box 948 Brookhaven, MS 39601	Greenwood Leflore Hospital 1508 Leflore Avenue Greenwood, MS 38930
Riverside Hospital Lakeland Drive Jackson, MS 39208	South Washington County Hospital Drawer 398 Hollandale, MS 38748
Biloxi Regional Medical Center 1559 Lafayette St. Biloxi, MS 39533	Memorial Hospital 4500 13th Street Gulfport, MS 39501
Mississippi Radiological Society 316 Medical Arts Building Jackson, MS 39201	Oxford-Lafayette County Hospital P.O. Box 946 Oxford, MS 38655



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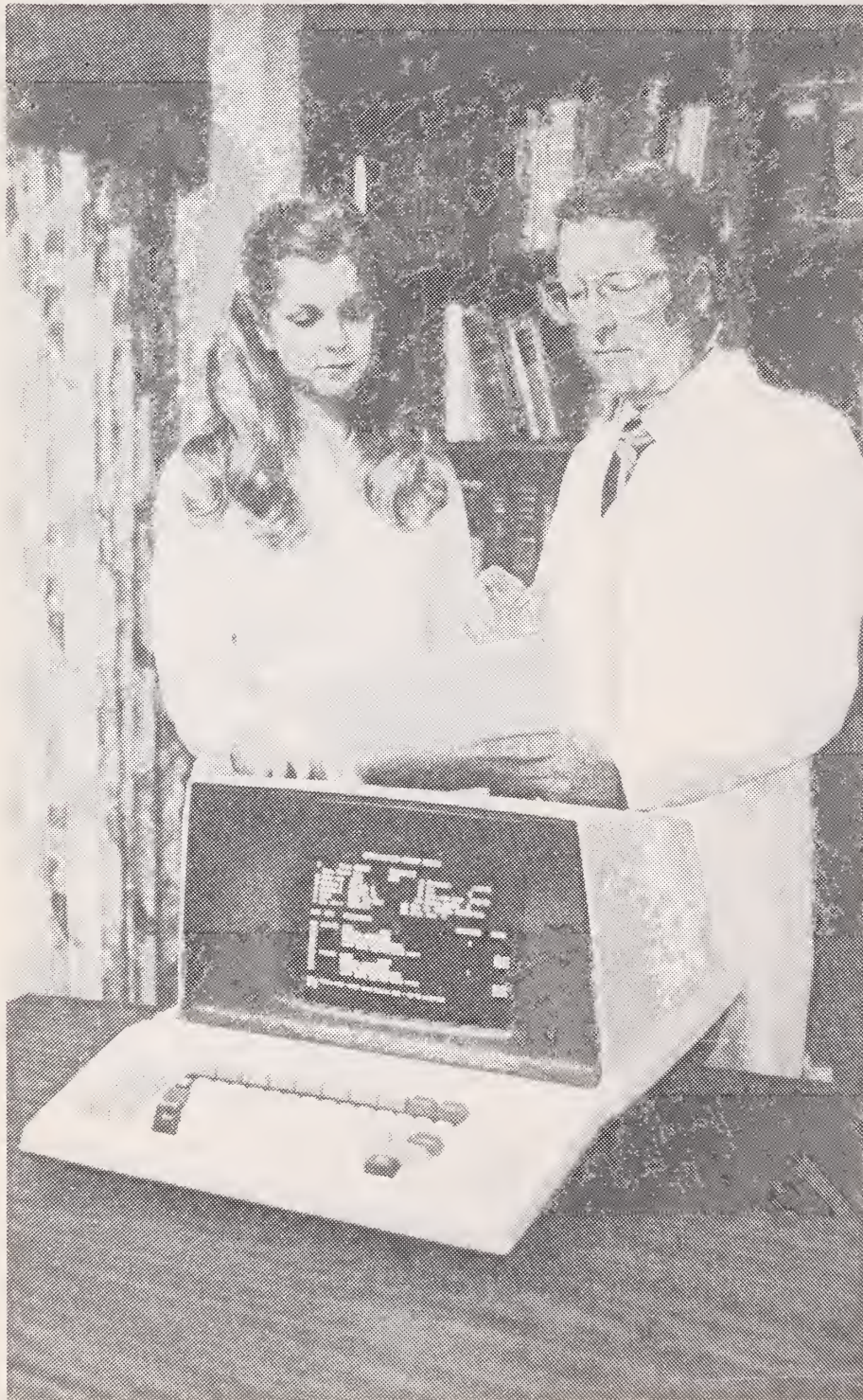
Barber, H.R.K.: *Female Patient* 7:OBG 40, 1982.

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DATELINE

Swing-Bed Program In Mississippi

Jackson, MS - Four Mississippi hospitals are participating in the swing-bed concept, which utilizes acute care beds in rural hospitals of less than 50 beds for extended care patients. The program enables long-term care patients to remain in their home community until a local nursing home bed becomes available or until the patient can return home. For information, contact the Mississippi Hospital Association, P.O. Box 16444, Jackson, MS 39236-0444.

SIDS Project Offers Counseling

Jackson, MS - Families who suffer the loss of a child through Sudden Infant Death Syndrome (SIDS) may benefit from counseling services offered by the SIDS project of the Miss. State Department of Health. In 1982, 110 apparently healthy babies died suddenly and unexpectedly in Mississippi. Lack of knowledge or misunderstanding about SIDS can compound shock and grief for the family, project spokesmen say.

Progress Toward Health Policy

Chicago, IL - The AMA's Health Policy Agenda for the American People came closer to establishing principles last month as its 150-member advisory committee met. The committee reviewed and commented on 148 draft principles and supporting information that had been developed by six work groups. Final drafts will be reviewed at a November meeting. MSMA's representative to the committee is Dr. Joseph C. Hillman of Brookhaven.

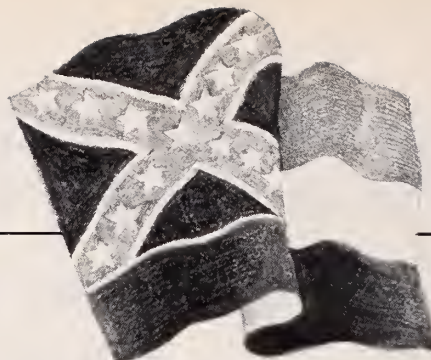
Adolescent Unit Opens At Riverside Hospital

Jackson, MS - Mississippi's first free-standing unit for adolescent psychiatric services opened early this month. Riverside Hospital's 30-bed Adolescent Unit features a program tailored to meet the specific needs of young people 13 through 17. Individual treatment plans will be formulated by a multi-disciplinary treatment team. The program emphasizes family involvement and continuation of the patient's regular school assignments.

Medicaid Faces Tight Budget

Jackson, MS - The Mississippi Medicaid Commission, projecting a \$13 million deficit for this fiscal year, is considering cutbacks in services and payments. The 1983 Mississippi Legislature appropriated no increase in funding for Medicaid. Future cutbacks in federal funding will necessitate an increase in state funding or even further cutbacks. MSMA is on record in support of co-payments on services instead of further cutbacks.

Roche salutes
the history of Mississippi medicine



SOLVING THE MYSTERY OF PASCAGOULA

More than 20 years ago, a combined demonstration of medical science and community effort turned an outbreak of infectious hepatitis in Mississippi into a national landmark of disease prevention.¹

When health officials in Pascagoula, Mississippi, reported more than a dozen cases of hepatitis, the Communicable Disease Center in Atlanta assigned an epidemiologist to aid local efforts in tracing the origin of the infection.

Nurses on duty at the Jackson County Health Clinic and physicians at Singing River Hospital were interviewed, as were the patients themselves. It soon became clear that the patients had not shared a meal, had not frequented the same restaurant and had not been together in any of the most likely sites for contamination. However, a startling fact did come to light... each of the 13 infected patients had eaten raw oysters within the previous two months.

Checking and double-checking the clues...

Raw oysters were a common food in Pascagoula, but at that time shellfish were not known to cause hepatitis. As a control, 13 names were selected from the city's

telephone book. Each person questioned denied having eaten oysters, and none had symptoms of hepatitis. The investigation was narrowing down, but there was still much probing to be done.

...to find the cause

With the assistance of a sanitation engineer and a shellfish expert, the investigators began the tedious task of inspecting the local stores, oyster plants, packagers and shucking companies. Finally, they found the source of the infections: an oyster bed at the mouth of the Pascagoula River, ordered closed to oystering some 30 years earlier because it was polluted.

The diligent work of 20 specialists—epidemiologists, virologists, bacteriologists, internists, pediatricians and public health officers—had led to an awareness of shellfish as potential hepatitis carriers, and to the need for closely regulating both shellfishing and water pollution protections. The work done in Pascagoula stands as a remarkable joint effort in the history of modern medicine in the United States.

Reference: 1. An era of specialists, chap. 5, in Lee RV, Eimerl S *et al*: *The Physician*. New York, Life Science Library, Time Inc., 1967, pp 107-109



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For the estimated 70 percent of nonpsychotic depressed patients who are also anxious,¹ Limbitrol provides both amitriptyline, specific for symptoms of depression, and the effects of Librium® (chlordiazepoxide HCl), the tested and dependable anxiolytic. Limbitrol is, therefore, a better choice for these patients than dual agents that contain a phenothiazine, a class of antipsychotic drugs used infrequently in nonpsychotic patients.¹

62% of Overall Improvement...Within the First Week

Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.²

In another multicenter study,³ the following symptoms associated with anxious depression were significantly reduced during the first two weeks of therapy:

- ☐ Headache—79%
- ☐ Early insomnia—91%
- Middle insomnia—87%
- Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.³

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jarvik ME; New York, Appleton-Century-Crofts, 1977, p. 316. 2. Feighner JP et al: *Psychopharmacology* 61:217-229, Mar 1979. 3. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

In moderate depression and anxiety

Limbitrol®

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Please see summary of product information on following page.

LIMBITROL® TABLETS[®] Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated. Sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12 5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, Prescription Paks of 50.

PHYSICIANS . . .

Information Kits Available for counseling pregnant women

Physicians, nurses and others who counsel pregnant women are now offered a "Smoking and Pregnancy" package for use in counseling about the risks of smoking during pregnancy and the health benefits of smoking cessation.

"Because You Love Your Baby, There Has Never Been a Better Time to Quit Smoking."

According to Dr. Roland B. Robertson, Jr. of Jackson, president of the Mississippi Lung Association, the two-part program, "Because You Love Your Baby, There Has Never Been a Better Time to Quit Smoking," offers information, handbook, charts, and full color posters to health care providers for use in counseling sessions. There is also a companion package available for pregnant women which provides useful information for smoking cessation and reinforces the counselor's message.

"National statistics show that nearly half the American pregnant women do not know how smoking affects the outcome of pregnancy. It is vital that pregnant women understand the health hazards of smoking," Dr. Robertson added.

The American Lung Association created the "Smoking and Pregnancy" kits for practitioner and patient to make it possible for the busy practitioner to educate patients for "life and breath." The new program helps pregnant women understand why they should quit smoking for themselves and their babies and encourages the use of the "Freedom From Smoking" program, a self-help program for persons wanting to quit smoking.


For more information on the new "Smoking and Pregnancy" program or to order materials, contact us.

MISSISSIPPI  LUNG ASSOCIATION

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Increasing incidence
of ampicillin resistance in
Haemophilus influenzae

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Haemophilus influenzae

H. influenzae

S. pneumoniae

Brief Summary. Consult the package literature for prescribing information

Indications and Usage: Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: General Precautions—If an allergic reaction to Cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antioglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cefclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Cefclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.^{1,6}

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

hour. The effect on nursing infants is not known. Caution should be exercised when Cefclor® (cefclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Cefclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs' tests, each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis, arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy include eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematologic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

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*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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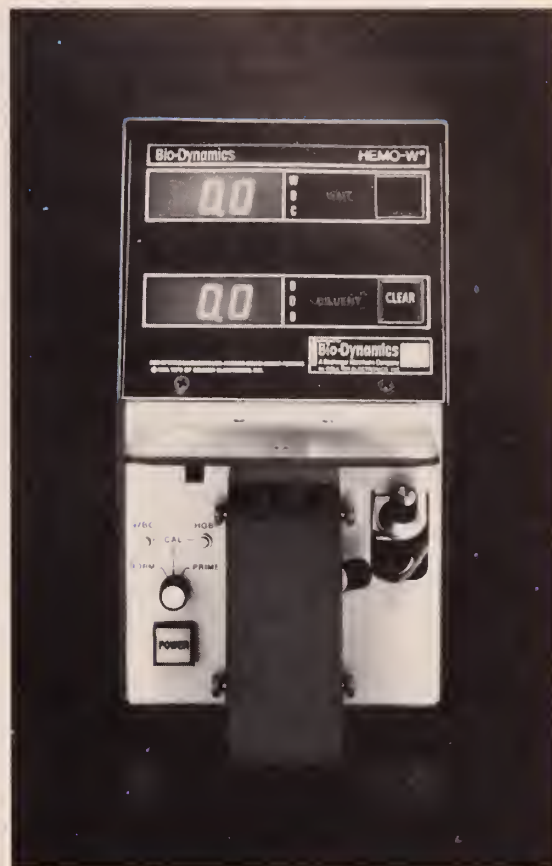
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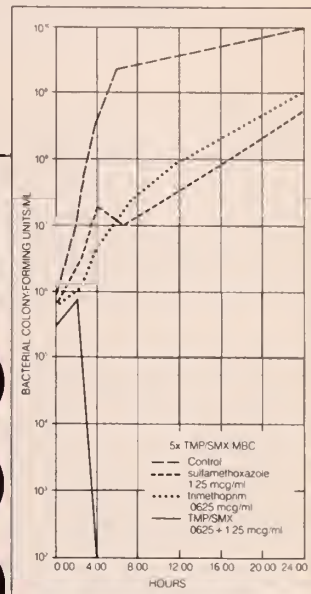
Percent of isolates of common uropathogens sensitive to BACTRIM and to other antimicrobials



[†]Analogous to cephalothin, the primary antibiotic disc used in testing.

Source: The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter Series, 1981-82. Numbers under percentages refer to the projected number of isolates tested.

RAPID IN VITRO DESTRUCTION OF *E. COLI**



Kill curve kinetics of Bactrim and its individual components against *E. coli* in vitro.¹

The bactericidal action of Bactrim has been demonstrated *in vitro* on laboratory strains of *E. coli*^{1,2} and on clinical isolates of *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and *Morganella morganii*³—the most common causative organisms of urinary tract infections.⁴ More than 100 published studies attest to the efficacy of Bactrim in recurrent urinary tract infections due to these organisms.⁵ In comparative studies with other antimicrobials, Bactrim has consistently demonstrated unsurpassed efficacy during therapy.^{6,11}

Resistance to Bactrim develops more slowly than to either of its components alone *in vitro*.^{*} Among urinary tract isolates, resistance has rarely emerged in susceptible strains.^{5,12} Bactrim is contraindicated in pregnancy at term, during lactation, in infants less than two months old and in documented megaloblastic anemia due to folate deficiency. Initial episodes of uncomplicated urinary infections should be treated with a single-agent antimicrobial.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

b.i.d. for recurrent urinary tract infections

^{*}*In vitro* data do not necessarily predict clinical results.

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Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL

PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients. **Pregnancy:** Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20 tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. **Pediatric Suspension,** containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). **Suspension,** containing 40 mg trimethoprim and 200 mg sulfamethoxazole per tea spoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).



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ORIGINAL PAPERS

Treatment of Malignant Hyperthermia With Dantrolene

J. M. COOPER, M.D.,
H. R. JONES, M.D., and
J. W. WILLIAMSON, M.D.,
Tupelo, Mississippi

MALIGNANT HYPERTHERMIA (MH) has been a dreaded occurrence for most anesthesiologists since it was first reported as a distinct syndrome of a hereditary nature in 1960.¹ Its incidence has been variously estimated from 1:10,000 to 1:100,000 anesthetic exposures.^{2, 3} The mortality in early studies was 70% to 80%³ and more recently with earlier recognition of the syndrome and more vigorous and definite treatment the mortality has been estimated to be 28%.⁴ Until dantrolene for intravenous use in the treatment of MH crisis was approved by the FDA in 1979, the anesthesiologist could only discontinue the triggering agents, institute aggressive total body cooling and treat the acidosis. Dantrolene is the only known specific therapeutic drug, but it must be given while there is still adequate muscle perfusion.⁵ A patient who responded rapidly to intravenous dantrolene is the object of the case report below.

Case Report

A 6-year-old, 50 pound (22.7 Kg), white female was seen in the emergency room on April 25, 1982, having been referred with a tentative diagnosis of acute appendicitis. She had a 24-hour history of generalized abdominal pain which had increased and localized in the right lower quadrant. She had no

Malignant hyperthermia is a rare and usually unsuspected hypermetabolic crisis that can occur during anesthesia. It is precipitated by inhalation agents and depolarizing neuromuscular blocking agents, and is often fatal. Dantrolene is the first specific therapeutic drug for this syndrome. The authors present a case report of an occurrence in a 6-year-old female and describe its successful management. They also discuss the anesthetic management of susceptible patients to prevent the occurrence of such a crisis.

upper G.I. symptoms, no vomiting and no upper respiratory symptoms. She had a negative past medical history with no prior hospitalization or anesthesia and was taking no chronic medications. She had no known drug allergies.

Physical examination revealed a temperature of 101°F (38.3°C), pulse 98 and respirations 24. Abdominal examination revealed exquisite tenderness in the right lower quadrant with peritoneal signs. The remainder of the physical examination was normal.

Admission laboratory studies revealed a hemoglobin of 12.9 gm and a WBC of 17,200 with 74% segs.

From the Departments of Anesthesiology (Drs. Cooper and Jones) and Surgery (Dr. Williamson), North Mississippi Medical Center, Tupelo, MS.

An appendectomy was recommended and a 20 ga. cathlon with lactated Ringer's solution was used to start an I.V. infusion in the left hand. Tobramycin 30 mg and clindamycin 150 mg were also given as an I.V. "piggyback." No preoperative sedation was given.

After the patient was taken to the operating room, EKG and BP monitors were placed and the pre-induction BP was 110/70 with a pulse rate of 130. Intravenous induction was accomplished with 2% thiopental totaling 100 mg, and 30 mg of succinylcholine was given to facilitate intubation.

Considerable masseter rigidity was noted, but a 5.5 mm cuffed orotracheal tube was placed without undue difficulty. Because of the masseter rigidity an esophageal temperature probe was inserted and the initial value was 37.8°C. Inhalation anesthesia was initiated utilizing 2% halothane and two liters nitrous oxide and two liters oxygen. The pulse rose to 150 and blood pressure to 120/80 immediately after intubation and then returned to 130 and 110/75 respectively during abdominal preparation and surgical draping. Twenty minutes after induction an additional 20 mg of succinylcholine was given intravenously to provide adequate surgical exposure. Relaxation appeared normal following this, and the pulse and temperature were 130 and 37.6°C respectively at this time. Approximately five minutes later, there was an onset of a rapid (150) bigeminy. Halothane was discontinued and 1.5% enflurane instituted as the anesthetic agent. Within two minutes the cardiac rhythm reverted to a sinus tachycardia. In approximately five minutes the esophageal temperature began to rise and an arterial blood gas sample (ABG) was drawn. The results were pH 6.97, pCO₂ 61, pO₂ 190, HCO₃ 13, base excess -18 which established the diagnosis of malignant hyperthermia. The temperature had now reached 38.4°C. All inhalational agents except for 100% O₂ were discontinued and the surgeon was informed of the crisis. Two ampules (88 mEq) of NaHCO₃ and 20 Mg of dantrolene sodium were given intravenously. The gangrenous appendix had been removed and abdominal closure was rapidly completed. The temperature increase slowed and stabilized at 38.6°C. With completion of wound closure, ice bags were applied to the groins and axillae. After ten minutes with no fall in temperature an additional 20 mg of dantrolene was given intravenously and the temperature began to decrease. Repeat ABG's at this time were pH 7.39, pCO₂ 36, pO₂ 517.

The patient was transferred to the surgical intensive care unit when the esophageal temperature reached 38°C and supplied with 40% O₂ by "T" piece. She was placed on a thermal blanket, and rectal probe, urinary catheter and an arterial catheter were placed for monitoring. Mannitol was given to maintain good urine output.

The endotracheal tube was removed in approximately 30 minutes as she was awake and "bucking" on the tube. Serial ABG's over the next 24 hours remained normal.

Chemistry studies drawn three hours post anesthesia revealed Ca++ 7.3, alkaline phosphatase 209, LDH 528, SGOT 194 and K+ 4.4. The CPK was 9,920 three hours post anesthesia, 56,358 the following day and 33,027 the second postoperative day.

The patient was transferred to the postoperative nursing unit the next day as she was alert with no further symptoms. She was discharged on the fifth postoperative day doing well with no temperature elevations above 100.2°F during the remainder of her hospitalization.

Her parents were questioned thoroughly about family history of anesthetic complications and none could be elicited. It is interesting to note, however, that a cousin has a history of severe "heat strokes" with limited outside work. Also the twin sister of the patient had an anesthetic at age one day without problems. The anesthetic record is not available, but it is probable that she did not receive any depolarizing muscle relaxants at that young age and it is rare for MH to occur under age two years.⁴ The family was counseled about the severity of the hyperthermia episode and its genetic nature. They plan to obtain medical alert bracelets for the patient and her twin. They will also relate the importance of this history to other family members, particularly the aforementioned cousin.

Discussion

Malignant hyperthermia (MH) is a hypermetabolic crisis, both aerobic and anerobic, precipitated by certain anesthetic agents and drugs resulting in intense production of heat, carbon dioxide and lactate. Virtually any potent inhalational agent can trigger MH⁶ but the onset is usually more abrupt when succinylcholine is used either by itself or in conjunction with volatile agents. Once initiated the reaction becomes a vicious circle in which the body temperature may exceed 43°C, pCO₂ values greater than 100 torr and arterial pH less than 7.00 often occur.⁵

Other frequent signs are tachyarrhythmias, dark blood in the surgical field, cyanotic mottling of skin, and hypotension. Muscle rigidity occurs in about 75% of patients.

Malignant hyperthermia is most prevalent in children, teenagers and young adults. Prior to puberty it occurs equally in males and females, and after puberty it is more common in males.² It was first thought to be inherited as autosomal dominant trait but now it is believed there is a multifactorial mode of transmission.⁷

The detection of MH susceptible patients prior to anesthesia is uncertain. Some will exhibit mild muscle abnormalities and joint hypermobility. The serum CPK will be elevated in about 70% of susceptible patients but there are many other causes of elevated CPK. The only accurate diagnostic test is a caffeine induced contracture measurement on a skeletal muscle biopsy.^{8, 9}

Malignant hyperthermia is triggered in proportion to the susceptibility of the patient and exposure to the triggering agent. Thus, in some mild cases, cessation of the anesthetic may be sufficient treatment. In fulminant cases dantrolene should be given early in I.V. doses of 1-2 mg/kg repeated as needed every 10 minutes to a total dose of 10 mg/kg. Hyperventilation should be instituted to correct the respiratory acidosis and NaHCO₃ given to correct the metabolic acidosis. Surface cooling, chilled I.V. solutions and irrigation of body cavities with iced saline should be instituted. Urine output should be maintained with furosemide and mannitol. Procainamide (not lidocaine) may be used to treat dysrhythmias. The use of steroids has also been advocated.¹⁰

If anesthetic management of a known susceptible patient is required, he should be well premedicated but phenothiazines should be avoided.⁵ Atropine should be avoided unless needed during the anes-

thetic. Oral dantrolene should be given for 24 hours prior to anesthesia in divided doses totaling 4-7 mg/kg/day. Anesthetic agents that are considered safe include nitrous oxide, barbiturates, opiates and droperidol. Pancuronium is considered a safe muscle relaxant. If regional anesthesia is used the esters are considered safer than the amides if used in large volumes. Some cases of MH have occurred several hours postoperatively so that the temperature should be monitored closely for 24 hours. ★★★

830 S. Gloster Street (38801)

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Radiologic Seminar CCXXXII: Balloon Embolization of Carotid-Cavernous Fistulas

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ADVANCES IN INTERVENTIONAL TECHNIQUES in recent years have brought the treatment of certain vascular malformations, including carotid cavernous fistulas and giant, unclippable aneurysms into the realm of the radiologist.^{1, 2} Such cases in years past have been considered poor risks for surgical cure although no other reasonable treatment was available. These advances in balloon catheter technique have dramatically improved the prognosis for this group of patients.³

Case Reports

Two patients were recently studied: Patient A received a gunshot wound to the face, and several weeks following the injury developed unilateral proptosis, chemosis, a loud bruit which was bothersome to him, and decreased visual acuity; Patient B sustained a basilar skull fracture when an automobile fell on him. This produced very similar clinical signs and symptoms. In both patients the diagnosis was made on clinical grounds and confirmed by selective angiography (see Figure 1). In each case it was possible to introduce a single 2 mm silastic balloon (of the detachable type manufactured by Beckton-Dickenson) into the fistulous tract and totally occlude the tract upon balloon inflation. This produced no compromise of the carotid lumen and actually improved carotid flow (see Figure 2). Both patients had rapid improvement in signs and symptoms although transient headaches did occur. At early follow-up, they are doing well without evidence of recurrent carotid cavernous fistula.

Discussion

Super selective catheterization for therapy was initially reported in 1971 when Serbinenko developed a detachable balloon micro-catheter designed for vascular occlusion. Debrun followed with

a similar catheter in 1974, and a silastic balloon was developed by Becton-Dickinson in 1977.³

The peculiarity in vascular anatomy in which the internal carotid artery passes through a venous structure, the cavernous sinus, predisposes to the development of the direct arteriovenous fistula. Disruption of the arterial wall is most often traumatic (75%) although occasionally spontaneous fistulas arise, usually from rupture of intracavernous carotid aneurysms. Symptomatology relates to the high flow state into the cavernous sinus including elevated pressures within the contiguous venous structures; of these the most important are the superior and inferior ophthalmic veins. The elevated venous pressure leads to engorgement of the ocular structures, proptosis, prominent bruits, ophthalmoplegia, chemosis, glaucoma, visual loss, and headache. These signs and symptoms may be noted bilaterally as cavernous connections across the midline are generally present. Secondary signs due to "steal" of blood from the ipsilateral cerebral branches may also occur. Spontaneous fistulas are more likely to occur from external carotid branches and have a greater incidence in spontaneous closure than the post traumatic variety.⁴

Surgical results in treatment of carotid cavernous fistulas have been generally unsatisfactory; even if the offending segment of the internal carotid is proximally occluded or isolated, the fistula often recurs through external carotid collaterals. This realization altered the therapeutic approach, and initial attempts at direct thrombosis of the fistulous tract were made by placement of coils of wire within the cavernous sinus as a thrombogenic maneuver.⁵ The advent of advanced balloon catheter techniques has improved results through the technique discussed in these cases. Debrun et al reported successful obliteration of carotid cavernous fistulas by balloon embolization in 53 of 54 patients, although a significant number (22) also required thrombosis of the affected carotid artery.⁶

Complications of the balloon closure method include pseudoaneurysm formation from partial defla-

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Figure 1. Selective internal carotid injection demonstrating bilateral filling of the cavernous sinus (arrows) through the fistula with very little intracranial flow.

tion of the contrast filled balloon, oculomotor nerve palsies with the sixth nerve being more often involved than the third nerve, and retroorbital pain. Less common complications include hemiparesis from inadvertent sacrifice of the carotid artery and pain from local pressure effects on the fifth cranial nerve.⁷ In Debrun's series, false aneurysm occurred in 44%, but when small were associated with few problems. Oculomotor nerve palsy occurred in nine patients and often was associated with large pseudoaneurysms and retroorbital pain. Five patients had to be treated for recurrent carotid cavernous fistula.⁶

In conclusion, this treatment modality is curative in most cases when all previous means were too dangerous and unsuccessful. It can be employed in the radiology department under local anesthesia, using conventional angiographic techniques. Because of the specialized nature of the equipment, seriousness of intracranial manipulations, and small number of cases, it should be conducted only in those centers where a neuroradiologist or interventional radiologist is available and with a neurosurgeon in close proximity, readily available to monitor any neurological changes that might occur as a result of the procedure. ★★★

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Figure 2. Following placement and detachment of a single 2 mm balloon (arrow), there is total occlusion of the fistulous tract without compromise of the carotid lumen. Note the marked improvement in flow to the middle and anterior cerebral branches.

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The Mississippi Transplant Program: Scope and Results

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END-STAGE RENAL DISEASE (ESRD) continues to be a major health care problem across the nation, both in terms of patient morbidity and expenditure of health care dollars. Currently, more than 500 Mississippians require some form of chronic dialysis for survival. In addition, approximately 125 new patients per year are added to this pool with ESRD.

Due to significant recent advances, renal transplantation will be increasingly considered as an alternative therapeutic modality in this group of patients.

The activity of the Mississippi Transplant Program over the last two years, emphasizing the improved results, is presented below. The immunological advances responsible for these improved results and the exciting prospects for the near future are briefly reviewed.

The first renal transplant procedure at the University of Mississippi Medical Center was performed as early as 1962. Since then, there has been a steady increase in the number of transplants performed (see Figure 1).

1980-1982 Activity

During the period of September 1980 through September 1982, 52 renal transplants were performed in 51 patients. Forty-three of these transplants were primary (ie, the patient's first transplant), eight were secondary grafts, and one patient received a third transplant during this period.

The mean patient age at the time of transplant was 30 ± 9 years. Thirty-five recipients (68.6%) were male and 36 (70.5%) were black. Chronic glomerulonephritis and hypertension were the most common

causes of renal failure in this group, being responsible for 41% and 25.5% of cases, respectively (see Table 1). This patient profile parallels in general the dialysis population in Mississippi.

TABLE 1
ESRD ETIOLOGIES

<i>Etiology</i>	<i>No.</i>	<i>(%)</i>
Chronic glomerulonephritis	23	(45.1)
Hypertension	14	(27.5)
Pyelonephritis	5	(9.8)
Focal glomerulosclerosis	3	(6.0)
Diabetes mellitus	2	(4.0)
Polycystic kidneys	1	(1.9)
Congenital hypoplasia	1	(1.9)
Lupus erythematosus	1	(1.9)
Post partum	1	(1.9)

Five patients (9.8%) received kidneys from living, related donors with the remaining 47 (90.2%) receiving cadaveric organs. All patients who received cadaveric grafts were placed on a preoperative transfusion protocol. Three to six units of blood were administered at bi-weekly intervals. The level of sensitization of HLA antigens was closely monitored by a lymphocytotoxicity assay against a random lymphocyte panel.¹

Twenty of the cadaveric transplants (42.6%) were performed using kidneys obtained within Mississippi, the balance being "shipped-in" from transplant centers throughout the southeastern region. This does not represent a disparity between the number of transplants performed and the number of organs harvested within the state; it reflects instead a regional effort to share kidneys among transplant centers so as to obtain the best possible tissue match for each patient.

From the Departments of Surgery and Medicine, University of Mississippi Medical Center, Jackson, MS.

All but one transplant performed in this time period was placed in an iliac fossa with end-to-side anastomosis of the donor renal vessels to the recipient external iliac vessels. A single kidney was transplanted intra-abdominally to the common iliac vessels because of previous bilateral groin surgery. Urinary tract continuity was reestablished in all patients by means of an endovesical ureterocystostomy.

Azathioprine and prednisone were the primary immunosuppressive agents for all patients unless some impairment of hepatic function was present. Cyclophosphamide was substituted for azathioprine in these patients. Acute rejection episodes were treated with pulse intravenous methylprednisolone over three days or with 14-day courses of antithymo-

cyte globulin. A limited number of patients who were allergic to antithymocyte preparations received external radiation for treatment of steroid-resistant rejection.

Results

There was no perioperative mortality (ie, within one month of transplant) in this group of patients. Post-transplant complications were generally related to the immunosuppressed state of the patient, and the majority can be divided into three major types: infectious, urologic and steroid-related. Twenty-seven infectious complications occurred in 15 patients and were the most common. In only three of these patients was the infection an isolated event. The majority of infections (82%) occurred in conjunction with some other type of complication or concurrently with another infectious complication. An analysis of all infections may be found in Table 2.

Urologic complications occurred in five patients (9.6%) (see Table 3). Ureteral necrosis, requiring reexploration and reimplantation of the donor ureter, occurred in two patients. It was not clear whether this was due to devascularization of the donor ureter during the harvesting procedure or ureteral rejection. Two patients experienced bladder hemorrhage that was easily controlled with cystoscopic fulguration and one patient had bladder disruption which closed with prolonged catheter drainage.

Four patients (7.8%) developed complications directly attributable to steroid administration (see Table 3). Duodenal ulcers that developed in two patients post-transplant may also have been steroid-related.

Twenty-six of the 52 reported patients are now one year or more post-transplant. Of these 26 patients, 17 have functioning kidneys yielding a one-year graft survival rate of 65.4% (see Figure 2).

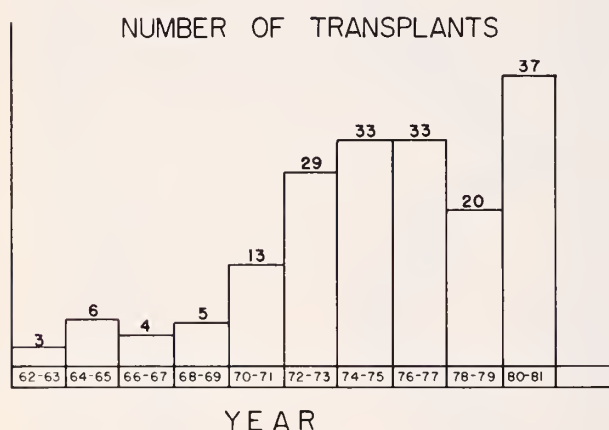


Figure 1. University of Mississippi transplant activity by year.

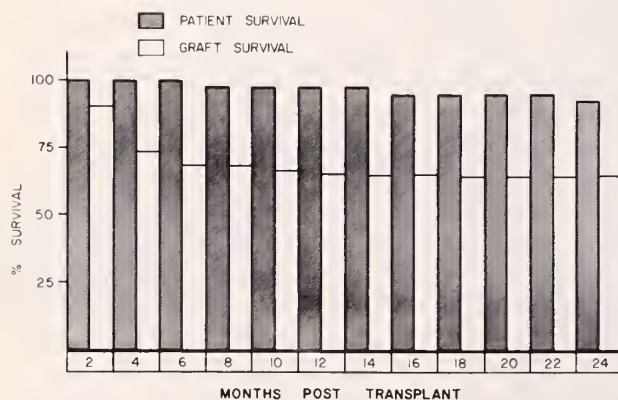


Figure 2. Patients and graft survival over the 24 month period ending September, 1981.

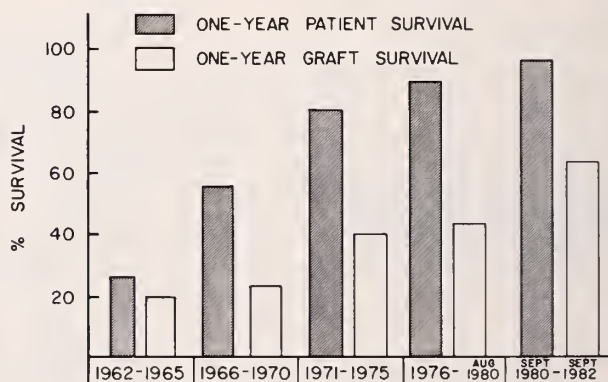


Figure 3. Improvement in patient and graft survival over the past 20 years.

Rejection was the cause of graft loss in all but two (78%) of the patients who have returned to dialysis. A single kidney was lost owing to a possible technical complication and one graft was lost to recurrent focal glomerulosclerosis.

Discussion

The results of renal transplantation have steadily improved in the Mississippi program, both in terms of graft survival and patient survival (see Figure 3). The current low patient mortality is particularly noteworthy. One-year graft survival of 65% for cadaveric transplants can now be expected in many major centers. The elements responsible for his improved outlook for multifactorial. Perhaps the most important factor in improved patient survival is the realization of the importance of avoiding over-immunosuppression.

A variety of new advances in transplantation immunology, tissue typing and immunosuppression have resulted in prolonged graft survival. Several of the modalities reviewed below are currently in use at our institution. Others, such as monoclonal ALG and cyclosporin A, are expected to be available in the near future.

Preoperative Blood Transfusions — The beneficial effect of pretransplant transfusion on graft survival was conclusively demonstrated by Opelz and Terasaki² in a computer analysis of the Renal Transplant Registry. While the precise mechanism of action is unclear, current evidence is supportive of an active immunologic process. To be effective, transfusion must be carried out 4-6 weeks prior to the transplant operation. Intraoperative transfusion appears to have no beneficial effect and may be detrimental.³

DR Locus Typing — Tissue matching based on a more recently discovered histocompatibility locus appears to be more advantageous than matching based on the more well defined HLA loci. A smaller number of alleles exist for this locus, making it possible to obtain a good match in a smaller population of patients than is possible with the A, B, and C loci. As a result, a suitable recipient for a harvested kidney can more often be found locally, precluding long transportation times which increase the chances of graft dysfunction. Also, good DR matching yields results comparable to those following pre-transplant transfusion even in non-transfused patients.

B-Cell Crossmatch — Specific donor-recipient crossmatching techniques utilized immediately prior to transplantation have become increasingly sophisticated. B-lymphocyte in addition to T-lymphocyte crossmatching is now routinely conducted

TABLE 2
INFECTIOUS COMPLICATIONS

Type of Infection	No.	(%)
Wound	7	(13.4)
Urinary tract	5	(9.8)
Pneumonia	4	(7.8)
Fungal	4	(7.8)
Candida	2	
Aspergillus	1	
Nocardia	1	
Sepsis	3	(5.8)
Prostatitis	1	
Orchitis	1	
Hepatitis	1	
Meningitis	1	

TABLE 3
NON-INFECTIOUS COMPLICATIONS

Complication	No.	(%)
Steroid-induced	3	(5.8)
Diabetes	1	
Psychosis	1	
Cataracts	1	
Urologic	5	(9.6)
Ureteral necrosis	2	
Bladder hemorrhage	2	
Bladder disruption	1	
Duodenal ulcers	2	(3.8)
Renal artery thrombosis	1	
Incisional hernia	1	
Aseptic bone necrosis	1	

in our institution. If preformed anti-HLA antibodies are suspected, procedures to detect "cold" and "warm" antibodies as well as autologous antibodies are carried out. As a result, hyperacute rejection due to circulating preformed antibodies has virtually disappeared.

Organ Procurement and Preservation — The importance of hemodynamic stability with attention to intravascular volume in the cadaver donor is now fully appreciated. In the last two years a definite trend toward static ice preservation, rather than continuous perfusion preservation, has occurred. While definitive figures are presently unavailable, the simplicity of ice storage has reduced procurement costs and in all likelihood also reduced early graft loss.

Antilymphocyte Globulin (ALG) — A gamma-globulin raised in rabbits against human thymic elements is now readily available. This potent agent is

assuming a clinical role in our institution as an effective secondary modality for the treatment of steroid-resistant rejection. Intravenous administration has largely eliminated painful local reaction and improved patient acceptance. As a result, the incidence of graft loss from irreversible rejection has been significantly reduced.

Monoclonal Antilymphocyte Globulin (ALG) — ALG raised against defined T-lymphocyte subsets appears to be more effective than conventional polyclonal antilymphocyte preparations. Preliminary reports have suggested that this agent may eventually replace steroids in the treatment of acute rejection.⁴

Cytomegalic Virus (CMV) Infection — The destructive role played by this ubiquitous viral agent in renal transplant patients has been fully appreciated only recently. Modification of immunosuppression during clinical CMV infection has been shown to be of major importance in terms of graft and patient survival; CMV screening of both donors and recipients is being increasingly utilized to avoid transplant transmission of this viral infection.

Immunological Monitoring — The use of monoclonal antibodies to identify T-lymphocyte subsets has revived interest in immunologic monitoring to predict an imminent rejection crisis. This technology has been particularly facilitated by the commercial availability of rapid cell sorting equipment.⁵ While its reliability as a predictive test remains far from absolute, this methodology may be particularly useful in evaluating rejection in the presence of CMV infection or acute tubular necrosis.

Cyclosporin A — This potent new immunosuppressive agent has received extensive evaluation in many European transplant centers.⁶ A major advantage of this agent is its low myelotoxicity and lack of interference with wound healing. Further improvements in renal graft survival rates can be expected

when this drug becomes available for general use.⁷ Many extra-renal organ transplants such as pancreas, heart, liver, small bowel, and lung are now or are soon to be clinically feasible with cyclosporin A.

Summary

Graft and patient survival data from the Mississippi Transplant Program are presented. There has been a steady increase in these parameters as well as overall activity in the two decades that the program has been in existence. The multiple factors, both immunological and non-immunological, that have been responsible for the improved results are reviewed. Because of continuous progress in these areas, further improvements in renal transplantation are expected. Extra-renal transplants are likely to become clinically feasible on a larger scale with the introduction of cyclosporin A, a promising new immunosuppressive agent. ★★★

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New Physician Payment System

AMA COUNCIL ON MEDICAL SERVICE*

Introduction

In the context of heightened concern about acceleration in health care spending and with exploration of alternatives to retrospective cost reimbursement for hospitals underway, increased attention is also being given by government, private payors, and the profession to the alternative methods under which payment can be made for physicians' services, and to the impact of each on the quality, accessibility, and costs of medical care.

In its Report K at the 1982 Interim Meeting, the Council alerted the House of Delegates to some of the problems for the profession seemingly resulting from use of the "UCR" [usual, customary, and reasonable] concept to establish third party physician payment levels, and further Council review of the entire subject of payment for physicians services was promised.[†] The purpose of the present report is to convey to the House the findings to date of that review. Specifically, this report will address two major issues:

- I. Whether present Association policy on the general subject of payment for physician services continues to be appropriate in the context of the three basic approaches to such payment — fee-for-service, "capitation," and salary.
- II. Whether, with specific reference to the "fee-for-service" approach, current and future problems resulting from use of the UCR concept to establish the amount of third party payment for physician services might be remedied by change to an indemnity-based system for such third party payment. (Such indemnity payments would represent a schedule of allowances and *not* a maximum fee schedule, with the physician charging the patient what he believes to be a fair and equitable fee.)

Synopsis

Present Association policy, which supports freedom of patients to choose their source of care and freedom of

At its June, 1983, Interim Meeting in Chicago, the American Medical Association considered the report and recommendation of the Council on Medical Services regarding payment for physicians' services. Specifically, the report centered on the three basic approaches to such payment — fee-for-service, capitation, and salary — and proposed an alternative to the "usual, customary, and reasonable" concept to establish the amount of third party payment. To obviate current and future problems associated with the UCR concept, an indemnity-based system for such third party payment has been proposed.

The following article discusses the facts and issues involved as reported to the AMA House of Delegates by the Council on Medical Services. This is an important subject, affecting the practice of every physician in this state and nation. The AMA has directed its state associations to inform its members on the indemnity system and communicate the members' opinions back to the AMA House in December of 1983. Comments regarding the report should be directed to MSMA's delegates to the AMA, Box 5229, Jackson, MS 39216.

physicians to choose their method of payment — including fee-for-service, capitation, or salary — continues to be appropriate.

Within the fee-for-service approach, current AMA policy supports the basing of third party payment levels on the "usual and customary or reasonable" concept, and the majority of private and public payors use the "UCR" concept in establishing payment levels. However, the increasing costs resulting from this approach have caused both private and public payors to be caught between mounting pressure to constrain plan outlays on the one hand and continuing consumer demand for comprehensive coverage of physicians' services on the other.

As one result, the "reasonable charge" used by payors — particularly public payors — in determining payment

* This report of the Council was presented at the June 1983 Interim Meeting of the AMA House of Delegates in Chicago; John J. Ring, M.D., served as Chairman of the Council.

† Past House Action: I-82:187; I-81:148-150; C-68:199; A-65:54.

levels no longer reflects the actual charges made by most physicians, because of infrequent updating of fee profiles, percentile cut-offs on customary charge data, and annual percentage caps on prevailing charge increases.

In addition, pressure is increasing on physicians to accept the payor-determined reasonable charge as payment in full (except for allowed deductibles or coinsurance) — i.e., to become “participating physicians.” Such pressure is exerted through:

- plan or company contracts which increasingly allow assignment of benefits or make payment only when services are provided by participating physicians;
- beneficiary misunderstanding of “explanation of benefit” letters and resulting patient/physician friction;
- “hold harmless” communications from payors to subscribers, and
- increased consideration nationally of mandatory assignment of fee schedules under Medicare.

As these trends continue, patients will be increasingly restricted to “participating” providers as a condition for insurance coverage. Eventually, physicians’ remuneration will be determined solely by third party payors for the great majority, if not all, of the professional services they render — with what the Council believes will be a resulting inevitable mediocrity in the quality of medical care.

The Council believes that the Association should seriously consider recommending that third parties change to an indemnity system of payment for physicians’ services.

Accordingly, the Council believes that the Association should seriously consider recommending that third parties change to an indemnity system of payment for physicians’ services, i.e., paying a set amount for services rather than some proportion of the “usual and customary or reasonable” charge. Such a set amount would be determined by the payor itself on the basis of claims experience, public demand, competition, and other relevant factors.

Such a change would benefit patients by:

- insuring their continued access to care not through external regulation of fees but through market forces;
- increasing both physicians’ and patients’ sensitivity to costs and quality of care provided;
- allowing them continued freedom of choice rather than being increasingly restricted to “participating” providers as a condition of coverage, and
- facilitating understanding and comparison of insurance coverages.

For third parties, rate determination would be simpler under an indemnity approach. Payors could establish premiums on the basis of prospective analysis of what the plan pays rather than on a statistical array of physician charges. Administrative costs should be significantly less. For government programs especially, it provides an alternative which permits budgetary restraints without further restrictions on type or duration of services covered or massive increases in enrollee copayment.

For physicians, this approach could bring improved patient-physician interaction, since neither physician nor patient will have false expectations of the amount of third party payment. Uncoupling third party payment from physicians’ charges could act to reduce legislative and political pressure for mandating physician “participation” as a condition of payment, and help preserve for physicians the freedom to charge what they believe to be a fair and equitable fee, subject only to normal and effective market constraints.

The Council believes that a change of this import in Association policy should be considered carefully by this House with their constituents over the next six months. The Council will also continue its study, and will submit recommendations at the 1983 Interim Meeting.

Is Present Association Policy on Basic Payment Mechanisms Appropriate?

There are essentially three ways in which a physician may be paid by patients, third parties, and/or employers for his professional services:

- (1) on the basis of work done — or fee-for-service;
- (2) on the basis of patients enrolled — or capitation; and
- (3) on the basis of time spent — or salary.

In *fee-for-service*, or payment on the basis of work done, the physician’s income varies in proportion to the services he performs. The total cost of care is not derived from a flat rate per person or a contracted number of physician hours at a set rate per hour, but rather from patient demand and physician response in each individual care episode.

In the *capitation approach*, a physician (or the group with which he works) accepts a fixed amount from a patient, in return for providing that individual all needed medical services over a specified time period.

The *salary approach* is, of course, a “time spent” mechanism. It can be payment by the hour, day, week, month, or year — payment which is independent of how many patients are seen or what is done for them.

The literature attempting to identify the incentives on professional behavior exerted by each of these payment approaches — and their impact on quality, accessibility, and costs of care — is extensive, and the arguments advanced in support of each approach are well known.

Proponents of fee-for-service note that the control of expenditures in this system lies primarily with the patient and physician rather than with external parties, and argue that this lack of superimposed financial constraint allows the physician to be much more responsive to each patient’s differing needs and demands. Detractors of this approach claim that this same flexibility creates incentives toward overtreatment, and that it is more difficult to predict and budget for total costs of medical care, both for the individual and the third-party payor.

Advocates of capitation claim that this approach contains built-in disincentives toward overutilization of services, encourages greater emphasis on preventive care, and tends to reduce the incidence of hospitalization and other high cost services. They add that costs of care are much more predictable under a capitation arrangement. Opponents tar capitation with the other side of the same

“utilization” brush, arguing that it fosters under-utilization of services in order to remain within budgetary constraints. They argue that, since payment depends on the number of patients enrolled, not on what is done for any one patient, the financial incentives act toward maximizing the patient list, and minimizing the amount of service per patient, with a resulting tendency toward risk selection and reduced access for high risk patients.

Salary arrangements offer perhaps the most direct control over the amount of physician reimbursement. Such arrangements can be attractive to physicians by providing steady incomes at acceptable levels, facilitating a regular work schedule, and providing a full range of fringe benefits such as vacation time, pension plans, and professional liability coverage. A salary arrangement also may be more feasible for some underserved communities which might not be able to support a fee-for-service medical practice — as witness the National Health Service Corps. On the other hand, patient needs could tend to suffer due to the time constraints of the physician contract, and physician productivity could be adversely affected, increasing the total costs of physicians’ services in the long run.

In the Council’s opinion, a comprehensive reexamination and analysis of the arguments for and against each payment approach would serve no useful purpose in this report. Each of these three approaches has its own inherent strengths and limitations, and — while fee-for-service has continued to be the dominant mode of physician payment in this country — no one method has clearly demonstrated its superiority for all patients or is most suitable for all physicians.

Further, the Council would emphasize that the financial incentives exerted by payment mechanisms *are by no means the only or even the primary determinant of physician behavior*. All three payment methods discussed above have built-in financial incentives toward inappropriate treatment — over-treatment in one instance and undertreatment or indifferent treatment in the others. Yet the Council strongly believes that most fee-for-service practitioners are conscientious in their attempts to provide only needed services, most physicians in capitation-type programs do their best to provide high quality care to all their patients, and physicians paid on a time-spent basis often continue providing care after the time paid for runs out.

Because concern for patients’ needs is the primary motivation in physician behavior, the patient is best served by having a variety of health care delivery and financing mechanisms from which to select the source of his or her care. It is the view of the Council, therefore, that present Association policy on this subject, which supports (a) freedom for physicians to choose the method of payment for their services, (b) freedom of patients to select their source of care, and (c) neutral public policy and fair market competition among all health care delivery and financing systems, continues to be appropriate.

Is Indemnity Preferable to UCR-Based Third Party Payment?

The major source of physician payment under the fee-for-service approach has become the private or public

... while fee-for-service has continued to be the dominant mode of physician payment in this country — no one method has clearly demonstrated its superiority for all patients or is most suitable for all physicians.

third party payor. In paying on a fee-for-service basis, such payors use one of two methods to establish the amount they will pay the physician or the patient for a particular service.

Under one method, variously termed a *benefit schedule or indemnity* payment system, the third party pays a set amount for a given service, which is determined by the payor on the basis of claims experience, negotiation with the insureds in some cases, and public demand. Schedules of this type are used in many Medicaid and workmen’s compensation programs and traditionally by the majority of commercial health insurance companies in their basic medical and surgical policies.

The alternate method for establishing the amount of third party payment under fee-for-service is to base the payment in some way on what physicians in the area usually charge for similar services — the “*usual and customary or reasonable*” concept. This UCR approach is used in some form by the entire Medicare (Part B) program, some of the Medicaid programs, most Blue Shield and other non-profit service plans, and most commercial insurance companies in their major medical and comprehensive policies.

In its Report K (I-82), the Council identified some of the problems it perceived as resulting from UCR-based third party payment, and indicated its intention to review this subject in depth. The remainder of this report conveys the results of that review to date, including comments received from state and medical specialty societies on the subject since the Council’s Report K (I-82) was submitted.

Existing Association Policy

Since 1965, it has been this Association’s policy that the “usual and customary or reasonable charge” concept should be the basis for establishing both government and private third party payments for physicians’ services. The terms “usual,” “customary,” and “reasonable” were defined by the Association in 1968, as follows:

Usual is defined as the “usual” fee which is charged for a given service by an individual physician in his personal practice (i.e., his own usual fee);

Customary is defined as that range of usual fees charged by physicians of similar training and experience for the same service within a given specific limited geographic or socioeconomic area;

Reasonable is defined as a fee which meets the above two criteria, or, in the opinion of the responsible local medical association’s review committee, is justifiable in the special circumstances of the particular case in question. (Resolution 48, C-68).

The inclusion of “reasonableness” as one of the three

criteria for appropriate payment was intended to afford specific protection to the patient through the availability of medical society review and sanction in those cases where a particular fee was not justified by the circumstances.

... unless there is a movement away from usual, customary and reasonable (UCR) reimbursement, medicine could become the captive of third-party payors.

UCR-based payment was first adopted on a local experimental basis by the Wisconsin Physicians' Service (Blue Shield) in 1954, at the urging of physician members. It became a statewide program in 1957, and was soon followed by similar programs in Iowa and California. By the mid-1960s, a number of Blue Shield plans as well as a few commercial insurers were using this payment methodology, although a number of others were hesitant to offer UCR policies because of lack of actuarial history and experience in establishing fee profiles. From 1966 on, adoption of UCR-based payment progressed much more rapidly — partly because a type of UCR methodology was mandated by the Medicare law and regulations for setting physician payment levels under that program, and carriers were thus forced to develop the capability to administer such programs.

As originally conceived and implemented, linking third party payment to physicians' actual charges offered a number of advantages to both physicians and patients; it enabled payor recognition of charge differences based on individual training, skills, and experience, as well as differences by area; allowed charges to reflect changing costs on a continuing basis; and assured patients access to covered services without undue economic hardship.

Focus of CMS Concern With UCR

However, as such comprehensive coverage became more widespread, a degree of insulation of both patient and physician from concern with health costs occurred. The subsequent escalation in health spending is now a matter of prime concern in public and private sectors alike. This concern has been intensified by the legal restraints now imposed against any attempt by the profession to help control health costs through fee review. As this House is well aware, under terms of the order issued by the Federal Trade Commission in May, 1982, the AMA is prohibited from taking or espousing any action which would interfere with either the amount or the form of compensation provided a member in exchange for his or her professional services. The FTC order, together with court decisions holding that the use of peer review committees to determine the reasonableness of fees (Pireno, etc.) is not exempt from antitrust litigation, have had a chilling effect on professional fee review.

Caught between mounting pressure to constrain plan outlays on the one hand and continuing consumer demand for comprehensive coverage of medical services on the other, public and private payors alike are reacting in ways which, in the Council's opinion, make it essential to

reexamine Association policy in this regard.

Specifically, two major trends have become evident:

- *Physician's vs Payor's Reasonable Charge* — the gap between the "reasonable charge" allowed by payors and the physician's actual charge is being widened;
- *Pressures Toward Participation* — pressures are increasing on physicians to accept the payors' version of the "reasonable charge" as payment in full — i.e., to become "participating" physicians — and to not bill the patient any additional amount (except for allowed deductibles and coinsurance).

These important trends form the basis of the Council's belief that unless there is a movement away from UCR reimbursement, *medicine could become the captive of third-party payors.*

Physician vs. Payor Reasonable Charge

The discrepancy between physicians' actual charges and those allowed under a "UCR-based" payment system is perhaps most striking in the Medicare program.

From the outset, Medicare's concept of "reasonable charge" differed from the profession's in several important respects. They differed, first, in definition. In contrast to Resolution 48 (C-68), Medicare defines a "reasonable charge" as the *lowest* of:

- (1) the actual charge made by the physician rendering the service;
- (2) the physician's "customary charge" for the service; or
- (3) the "prevailing charge" for the service in that locality.

The "customary charge" is defined by Medicare as the individual physician's median charge for the service, an amount which would cover his charge at least half the times he performed the service. The "prevailing charge" is essentially the amount which would cover the "customary charge" for the service in that area a *certain percent* (90%, 75%, etc.) of the times it is performed. From enactment of Medicare until 1971, Medicare carriers were allowed to establish their own percentile cut-off for the prevailing charge — and set it as high as 90% in some areas. In 1971, the program changed from carrier-determined prevailing charges to a nationally-determined prevailing charge defined as the 75th percentile of customary charges for physicians of like training and skill, weighted by frequency, i.e., an amount which would cover the "customary charge" for the service in that area at least three-fourths of the times it is performed. Physicians are then paid 80% of the Medicare-defined "reasonable charge" for covered services to beneficiaries.

Medicare's approach also differs from AMA's UCR concept in that the amount of Medicare payments lag further behind current physician charges, since they are based on charge data up to 2½ years old. Both the "customary charge" and the "prevailing charge" are calculated from data on physician's charges during the calendar year before the fiscal year in which the claim is submitted; therefore, Medicare payments for most physicians' services are based on what the physician was charging 1-2½ years previously.

Finally, the two concepts differ in that, since 1976, the allowable yearly increase in Medicare payments is further limited by an "economic index" established by the Health Care Financing Administration. The "Economic Index" regulations of June 16, 1975, established a maximum percent of increase in "prevailing charges" allowable for any year over the prevailing charges in effect during fiscal year 1973. Thus, the allowed yearly percent of increase is limited not only by actual increases in physicians' charges but also by an economic index established by the Department of Health and Human Services, which is intended to reflect increases in the cost of doing business.

The index operates on the assumption that 40 percent of a physician's income goes to expenses and 60 percent to net income. It allows an expense-related increase in the prevailing charge based on data on salary increases in non-medical service industries, on increases in housing and transportation costs, on wholesale price increases for drugs and pharmaceuticals, and (for miscellaneous costs) on consumer price index increases. An increase in the net income component is allowed in proportion to increases in the earnings of production and nonsupervisory workers, adjusted to eliminate productivity increases. The "economic index" is calculated annually by HCFA and furnished to all carriers.

Since its inception, the yearly increases in prevailing charges allowed by the index have been generally less than the overall inflation rate, thus progressively increasing the gap between physicians' charges and Medicare payment.

For fiscal year 1984, the Administration has recommended a 1-year freeze on physicians' customary and prevailing fee levels — an even more stringent constraint on Medicare reimbursement amounts.

This progressively increasing discrepancy between physicians' costs and charges and Medicare payment* has been a major reason for the decrease in frequency of assigned Medicare claims since the program's inception. In 1969, physicians agreed to accept Medicare reimbursement as payment in full except for allowed deductibles and coinsurance in 61.5% of all claims; by 1980, that proportion had dropped to 51.5%. Most recently, 1982 year end data from AMA's Socioeconomic Monitoring System indicate that the proportion of assigned Medicare claims has dropped to 42%. These same data indicate that 69% of physician respondents identified inadequate Medicare reimbursement as an important reason for their not accepting assignment.

The discrepancy between actual charges and third party payment levels appears to be less across the other major source of UCR-based payment — the 69 Blue Shield plans presently in operation. According to Blue Cross/Blue Shield Association representatives, the majority of local plans use the 90th percentile, rather than the 75th as

in Medicare, as the cut-off point for establishing prevailing charges. This may help account for the relatively high and stable rate of physician participation across those plans with participation agreements† reported by BC/BSA representatives — a rate averaging about 80%. However, two state medical societies did specifically communicate to the Council their concern with present or expected efforts by private payors to further restrict the amount payable under their UCR policies.

In addition, first quarter 1983 data from the AMA Socioeconomic Monitoring System indicate that 60% of those physicians electing not to enter into Blue Shield participation agreements in those areas where such agreements were offered did so because of insufficient reimbursement from the plan.

Pressures Toward "Participation"

Physicians are coming under increasing pressure to become "participating" providers — to accept the payor's version of the "reasonable charge" as payment in full and not bill the patient for any additional amount except allowed deductibles and/or coinsurance. Such pressure takes several forms.

1) *Refusing assignment or payment to non-participating physicians*

Virtually all of the contracts written by Blue Shield plans with participation agreements will allow assignment of benefits to the physician by the subscriber *only* if the physician has entered that participation agreement, will accept plan reimbursement as payment in full, and will refrain from "balance-billing" the patient. Non-participating physicians must recover their fee directly from the subscriber. As noted previously, Blue Cross/Blue Shield representatives expect most of the 10 local plans presently without participation agreements to attempt to institute such arrangements shortly. The Council has been informed that Blue Shield is changing or planning a change to this approach in Arkansas, Indiana, and Ohio, and may be considering it in other states as well.

Blue Shield of Massachusetts and some plans in the state of Washington apparently have a more extreme form of participation agreement, *wherein no payment is made to either physician or patient for services performed by a non-participating physician*. The Massachusetts program has been under litigation by the Massachusetts Medical Society for the past 4 years. Other medical societies are considering litigation against their state plans. At issue is whether, among other questions, Blue Shield can unilaterally refuse to honor assignments by enrollees to non-participating physicians, or refuse payment entirely for services of such physicians.

A review of existing state legislation in this regard is informative. Statutory excerpts from relevant state laws relating to freedom of choice of provider and to payment of such providers — for both medical service plans and commercial insurers — have been analyzed by the AMA Department of State Legislation.

According to that analysis, at least 32 states either allow or do not expressly prohibit non-profit service plans from issuing the above-noted contracts allowing assign-

* Nationally, Medicare disallowed 19.5% of total physician charges submitted for Medicare beneficiaries in 1977 (the most recent year for which data are available).

† About 10 plans presently have no participation agreements with area physicians. According to BC/BSA representatives, this number is expected to decrease fairly rapidly over the next few years.

ment of benefits only to participating physicians. All states but one either allow or do not expressly prohibit such non-profit plans from making payment directly to subscribers for services of non-participating physicians. However, such plans are not as a rule *required* to make such direct payment to subscribers for services of non-participating physicians.

Stated another way, it would appear quite possible that, in many if not most states, applicable state legislation generally would not prohibit non-profit service plans from marketing contracts which would refuse payment *entirely* for service rendered by non-participating providers.

Such a set amount would be determined by the payor itself on the basis of claims experience, public demand, negotiation with insureds, and other relevant factors. As noted previously, these indemnity payments would represent a schedule of allowances, and not a maximum fee schedule.

While commercial insurance companies are on the whole still subject to relatively stringent state prohibitions against any contractual restriction in the subscriber's freedom of choice, there appears to be relatively little statutory impediment to *non-profit medical service plans* in other states following the lead of those in Massachusetts and Washington.

2) Misleading or inflammatory explanation of benefits to subscribers

The Council has for a number of years been attempting to obtain improvement of private and public third-party communications to policyholders which, in the profession's opinion, provide an inadequate explanation of the insurer's methods of determining the benefit payable for a service and lead to patient misunderstanding.

The problem is especially severe currently in communications from private payors with UCR-based payment mechanisms, where the language used has often conveyed the implication that any fee greater than the amount paid by the insurer is, by definition, "unreasonable." Compounding this problem has been the continuation in some areas of communications from both medical service plans and commercial companies to their policyholders with UCR-type coverage, offering to defend policyholders in any legal action brought by a physician to recover the amount of his fee not covered under terms of the policy.

Strong concern with both of these problems — misleading "explanation of benefit" language and "hold harmless" communications — have been a recurring theme in medical society comments to the Council on this subject. Again, however, legal constraints hamper any organized professional effort to deal with these problems through discussions with private payors, assistance in fee review, or similar activities. Such constraints led the Council to conclude, in its most recent report to the House on this subject, that "solutions must be found that do not

require the cooperation of the health insurance industry or the medical service plans." (CMS Report F, I-81)

3) Mandatory assignment under Medicare

The past few years have seen increasing discussion in government sectors of the potential viability of legislation to mandate assignment as a condition of payment under Medicare, to require all physicians who treat Medicare patients to accept program reimbursement as payment in full, except for allowed deductibles and coinsurance, or to impose maximum fee schedules for services to beneficiaries. Such discussion will continue and further intensify as the present Administration seeks ways of paring a federal deficit now projected to reach \$267 billion in 1988.

A more recent and perhaps even more significant development has been the enactment of legislation in Congress calling for development of a DRG-based prospective pricing proposal for *physicians' services* in hospitals, as a part of proposals for prospective pricing of hospital services under Medicare. At the time this report was written, a final version of Medicare hospital payment program based on diagnosis related groups (DRGs) had been approved by Congress and sent to the President. One provision of the new law calls for HHS to report in 1985 on the "advisability and feasibility" of applying DRGs to physician charges for hospital services and of legislation to effect such a change. (A more complete description of this legislation appears in CMS Report A, also before the House at this meeting.)

The Future

If the trends and forces identified above continue to operate into the future, the Council can foresee only one logical outcome:

- If the acceleration in spending for health care continues to be fueled by the insulation of both physician and patient from cost concerns . . .
- If unions, consumer groups, and the public continue to press for comprehensive coverage of physicians' services . . .
- If payors continue to react by marketing more UCR-based policies requiring physicians "participation" as a condition of payment — and consumers continue to purchase such coverage . . .
- If such mandated "participation" also becomes a part of the Medicare law . . .
- And if federal agencies continue to chill any professional attempts to deal with these problems through discussions and negotiations with payors . . .

Then medicine in effect will become the captive of public and private third party payors — as they already have in a number of other countries — in that their level of remuneration will be determined solely by those payors for the vast majority if not all of the professional services they render — with the resulting inevitable mediocrity in the quality of medical care.

The Council has concluded, therefore, that this is the proper time to reevaluate the Association's policy that UCR be the basis for all third-party payments to physicians. The Council wishes to emphasize that this reeval-

uation applies *only* to the basis for third-party payment, not to the more basic issue of how the individual physician in his own practice should establish his fees.

After substantial and in-depth consideration, the Council is of the opinion that serious consideration should be given by all third-party payors, government and private, to a change to an *indemnity system of payment for the majority of services provided by physicians*, i.e., paying a set amount for services rather than some proportion of the "usual and customary or reasonable" charge. Such a set amount would be determined by the payor itself on the basis of claims experience, public demand, negotiation with insureds, and other relevant factors. As noted previously, these indemnity payments would represent a *schedule of allowances*, and *not* a maximum fee schedule; the physician would continue to be free to charge the patient what he believes to be a fair and equitable fee for his services.

The Council believes that such a change will be to the immediate and long-term advantage of patients, third parties, and physicians.

For patients, it will assure continued access to care *not* through external regulation of fees, but through the more effective mechanism of the marketplace, by increasing both physicians' and patients' cost awareness. The fee will again become the business of the physician and patient, with increased sensitivity by both to the quality and costs of care provided. This could, in fact, become an important "consumer choice" approach, since the patient will have a more substantial incentive to seek a physician whose fees are reasonably related both to patient satisfaction with care and to the amount Medicare or his or her private insurance pays, and to explore the reasons for differences in physicians' charges. It will allow patients continued freedom to seek the best in medical care, rather than being increasingly restricted to "participating" providers as a condition for insurance coverage. For those in the market for private insurance coverage, it will be much easier to understand and compare extent of insurance coverages — another "consumer choice" goal this Association has long supported. For Medicare beneficiaries as well, selection of supplementary private insurance plans tailored more precisely to Medicare coverage "gaps" will be simplified.

For third parties, rate determination is simpler under an indemnity approach: payors can establish premiums on the basis of prospective analysis of what the plan pays rather than on a statistical array of physician charges; administrative costs should be significantly less. For government programs especially, it provides an alternative which permits more precise budgetary forecasting without further restrictions on type or duration of services covered or massive increases in enrollee copayments. For programs such as Medicare and national private health insurance accounts, the indemnity amounts could vary from one region to another based on cost-of-living differences. Market forces would act to insure that the indemnity amounts under private plans would be set at a reasonable and competitive level, and increased as economic conditions dictated. For Medicare, consumer and professional groups alike could continue their advocacy for

The Council believes that this approach can bring improved patient-physician interaction, since neither physician nor patient will have false expectations of the amount of third party payment.

reasonable and economy-indexed increases in indemnity payment levels, as they do now under the present reimbursement approach.

For the profession, the Council believes that this approach can bring improved patient-physician interaction, since neither physician nor patient will have false expectations of the amount of third party payment. *Uncoupling third party payment from physicians' charges will reduce legislative and political pressure for mandating physician "participation" as a condition of payment (which in effect would constitute a maximum fee schedule) and help preserve for the profession the continued freedom to charge what they believe to be a fair and equitable fee, subject to the normal and effective constraints of the market.*

The only exception to use of an indemnity-based approach to payment levels would be in the type of "catastrophic" coverage offered under both private and public payor programs where no further coinsurance or copayment is imposed once the beneficiary has spent a specified amount out-of-pocket. In order for such catastrophic coverage to provide meaningful protection to beneficiaries on the one hand and offer some degree of cost predictability to payors on the other, both the amount of patient spending allowed to count toward meeting the out-of-pocket spending limit and the amount of third party payments *in the catastrophic portion of their plans* should continue to be related in some way to the actual charges of physicians. To illustrate, if the plan was paying for physicians' services on an indemnity basis, the *entire difference between the indemnity payment and an individual physician's actual charge* — no matter how high — could theoretically be applied toward meeting the catastrophic threshold. In the Council's view, it would be more appropriate to allow only the difference between the indemnity payment and *physicians' customary charges* (or a certain percentile thereof) in the area to count toward the catastrophic threshold.

By the same token, once the catastrophic threshold is reached, most insurance plans currently do not pay *all* additional expenses incurred for covered physicians' services, but rather at a percentile of physicians' customary charges for these services, but without imposing coinsurance on the beneficiary. If a plan paid on a *flat indemnity basis* above the catastrophic threshold, some patients could continue to have major out-of-pocket expenditures for physicians' services. On the other hand, payment for *all* costs of physician services above the catastrophic threshold could be extremely expensive for the plan. Accordingly, the Council believes it would be desirable for payors to continue to relate their payment for physicians' services to physicians' customary charges *in the catastrophic portion of their plans*.

The Council recognizes that such a change to indemnity-based third party payment for most services provided by physicians represents a significant departure from past AMA policy. This is especially true in light of the fact that the UCR method of health insurance payment for physician services began with a major thrust from the sponsorship of state medical associations and, later, of this Association. However, as health insurance has grown, it has also become a strong and independent entity.

In the past decade, the AMA has given formal recognition to that independence by first, in 1976, discontinuing appointment of members to the national Blue Shield Association Board, and, second, by establishing the policy that the Association should avoid supporting a competitive advantage to any one type of health insurance company.

The Council recognizes that such a change to indemnity-based third party payment for most services provided by physicians represents a significant departure from past AMA policy.

The Council believes this principle has served the Association well, and believes that the recommendation it makes here is a valid and appropriate extension of that policy. Further, the Council is of the opinion that the recommendation of indemnity-type payment methods makes even clearer the Association's determination that such third parties are and will remain separate and distinct from organized medicine, serving the patient rather than the physician.

This approach will not preclude the Council's continuing to meet with representatives of both the Blue Shield plans and the Health Insurance Association of America in efforts to improve the cost-effectiveness of medical care and in such *pro bono publico* efforts as the promotion of community health care coalitions.

The Council recognizes that this recommendation is one which third party payors may not choose to implement at once. For the service plans in particular, such a change represents a major shift in their approach to coverage for basic health expenses. However, the Council believes that in the long run it will not only be to the advantage of such payors, but that it leads the nation in the appropriate direction.

The Council also believes that a change of this import in Association policy should not be made precipitously, but that members of this House, and the Federation as a whole, should carefully evaluate for themselves the arguments for such a change before taking action.

Appendix

Questions Regarding UCR and Indemnity

Question

If private and public payors were to change to paying for physicians' services on an indemnity basis, what would prevent such payors from then requiring physician acceptance of the *indemnity amount* as payment in full —

in effect, converting such indemnity payment to a maximum fee schedule?

Answer

For the Medicare program, first, requiring all physicians who treat Medicare patients to accept program reimbursement (whether a "UCR"- or indemnity-based amount) as payment in full would require a change in the Medicare law. From the program's point of view, uncoupling payment levels from physicians' actual charges would reduce the need for such legislative change, since it would eliminate the continuing cost push on program spending exerted by UCR-based payment and allow much more predictable budgeting. It is true that, if Medicare changed to an indemnity basis, beneficiaries would probably exert political pressure to prohibit balance billing by physicians. *However, they are already exerting such pressure because of the growing discrepancy between Medicare's "reasonable charge" and physicians' actual charges.* In the Council's opinion, the only net political effect of changing Medicare to an indemnity basis would be to eliminate one of the important "justifications" advanced for such mandated assignment and ban on balance-billing — the assertion that "our payment is based on what most physicians charge anyway."

With regard to private payors, it should be remembered that what the Council is suggesting is a change to *indemnifying the patient* against health care expense; a contractual relationship would exist only between payor and subscriber, not between payor and physician. It could be a violation of the antitrust laws for service plans and commercial companies to market an indemnity plan which would pay only when the physician accepted the indemnity amount as full payment. As a practical matter, too, it would be difficult for such plans to survive in a competitive market, *since they could offer no assurance to subscribers of any reasonable level of access to covered services* — that is, few physicians would be likely to commit themselves to accepting as full payment an amount no longer contractually tied to actual charging patterns.

Question

Since unions and consumer groups have exhibited a strong and continuing preference for comprehensive, service-type benefits, will changing to an indemnity system drive more of them out of the fee-for-service sector and into alternative, capitation-type systems?

Answer

It is probable that the premiums for coverage under capitation-type systems will be generally *higher* than those for indemnity coverage under traditional insurance plans. A recent study by the Congressional Budget Office indicates that the average premium for HMO family coverage *now* is higher than that for traditional health insurance plans (\$132/month for HMO coverage vs \$104/month for all employment-based insurance). The tax law and other changes in the six AMA "consumer choice" principles presently supported by AMA would reduce the attractiveness of such more expensive coverage.

Even if premiums for the two types of coverage were

comparable, a further shift to capitation-type programs should occur only to the degree that traditional systems are unable to compete on the basis of *either* price or quality/accessibility. But if traditional fee-for-service medicine offers a better product, patients will still be willing to pay more for it.

Question

If private and public payor levels are uncoupled from physicians' actual charges in an area, how would regional differences in cost be allowed for? In addition, would inflation act over time to make the indemnity allowances increasingly inadequate?

Answer

For programs such as Medicare and national private health insurance accounts, the indemnity amounts could vary from one region to another based on cost-of-living differences. Market forces would act to insure that the indemnity amounts under private plans would be set at a reasonable and competitive level, and increased as economic conditions dictated. For Medicare, consumer and professional groups alike could continue their advocacy for reasonable and economy-indexed increases in indemnity payment levels, as they do now under the present reimbursement approach.

Question

If the Medicare program paid for physicians' services on an indemnity basis, how would this affect Medicaid?

Answer

A physician who treats a Medicaid patient and bills for

his services is already required by law to accept the amount of the state agency's reimbursement as payment in full. Almost half the programs now pay on the basis of a fee schedule set by the state agency. Those states where payment is now the same as or a percentage of Medicare rates would have the option of establishing their own fee schedule or of keying payment to Medicare's new indemnity levels. To forestall even further reduction in access to care for beneficiaries in these latter states, consumer and professional groups would need to continue and perhaps intensify their advocacy for reasonable Medicaid payment levels.

Question

Will the majority of physicians in fact be willing to now deal solely with the patient in fee matters, or will they continue to prefer to accept a lesser but "guaranteed" payment from the third party?

Answer

The Council believes this is a key question. The Council further believes that the majority of physicians will choose to make this change, if they perceive clearly the long-term adverse consequences of not doing so.

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Mississippi State Medical Association Auxiliary

Images

DRG's . . . increased malpractice litigation . . . medical care competition . . . cost containment . . . impaired physicians. . .

Never before in the history of medicine has the medical profession, and quite naturally our medical auxiliary, come under such intense scrutiny. The image which our spouses and we project is more critical now than ever before. Our 1983-84 auxiliary year will focus on this timely theme.

Goals and objectives have been developed to provide the "looking glass" for us to enlarge our vision of auxiliary as it relates to self, community, and the medical profession.

Our first emphasis concerns "Self Image." Through a series of self-growth learning experiences, the medical spouse will be afforded the opportunity for evaluation and enhancement of self image in a world of transition and changing life styles.

As we examine "Auxiliary Images," two objectives appear that are vital to the life blood of our auxiliary and your profession. The first of these involves increased participation in the political process; the November general election will provide a final opportunity this year to accomplish this objective.

The success of the second objective will indeed determine our future, for increased membership and participation in auxiliary is essential for our survival. And this year, you will play a critical role in that success as dual billing has been reinstated.

"Community Images" features participation in projects such as Remove Intoxicated Drivers and Child Abuse and allows us to show our concern for the health and welfare of our communities.

Finally, we will strive to improve our image with the medical profession by fostering a closer auxiliary-association relationship. A gesture of our sincerity in this regard is a pledge of \$10,000 to the Caduceus Club for the Impaired Physicians' Program.

As we begin a new year, I invite you to reflect on your image. If you, like me, discover room for improvement, hopefully you will tap resources to bring that image into sharper, more positive focus.

★★★

MRS. STANLEY HARTNESS
President, MSMA Auxiliary





The President Speaking

First Course Served at Fed Dinner Dance

Whitman B. Johnson, Jr., M.D.
Clarksdale, Mississippi

The government's dinner dance for "providers" has arrived, and the first course is served to the hospitals this month. It's Alphabet Soup in the name of DRGs. The American Hospital Association is looking forward to the serving like a dog eyeing a steak bone; but it makes one wonder if they were sold a bill of goods or if they ever looked at the side of the menu with the price.

Any time that the federal government serves free lunch, it's obvious that Mississippi physicians especially need to be careful that they and their patients don't get ptomaine poisoning. The AMA has opposed this program as being too broad and all-encompassing to impose on the entire country at once without trying it as a pilot project in a small area first. The only state with any experience to speak of in the field is New Jersey, and they have recently started an investigation to see if there isn't an increased mortality secondary to the earlier discharges following the institution of the program in that state. Their experience is only for three years.

We in Mississippi have a different social mix than most states in that we have a higher segment of older poor people who enter the hospital and have no younger family to care for them when they are ready for discharge. At the same time, those who are the least able to care for themselves are the hardest to place in nursing homes for that very reason. The nursing homes don't want the really sick patients because they are too expensive to care for. This increases hospital stay, although there are nursing home beds available for them.

The traditional religious involvement in care of the poor has and will decrease as government gets more involved. They do not feel the need to spend money as long as the feds will do it.

Soon after the soup is served, look for the hospitals to start the dance which will be known as the "diagnostic creep." In other words, hospitals will want the maximum possible diagnosis so they can receive the maximum payment. This can be self defeating for physicians since the DRGs are going into data banks to be used on us as soon as possible. For example, a patient is admitted with upper G.I. bleeding, the bleeding stops, G.I. series shows all the changes of peptic ulcer disease except a crater, the radiologist's diagnosis is probable peptic ulcer, and the patient goes home on treatment in four to five days. The administrator would like to have

(Continued on page 292)

Indemnity vs. UCR Reimbursement

A proposal that promises to generate much discussion among the profession will be before the AMA House of Delegates at its December 1983 meeting.

The proposal is officially cited as "Report D of the AMA Council on Medical Service." It concerns the AMA's supporting indemnity reimbursement for physicians' services in lieu of its longstanding support for "usual, customary and reasonable fee" reimbursement.

Report D appears in its entirety in this issue of your JOURNAL MSMA. Your MSMA Board of Trustees, Officers and AMA Delegates urge your thoughtful review of the report. Aside from its objective to reach a decision among the profession for future AMA action, the report presents an excellent overview of the development and current status of reimbursement for physicians' services.

Your comments and suggestions regarding the report may be sent to MSMA or to your delegates to the AMA: Drs. James O. Gilmore; Sidney O. Graves, Jr. and W. Lamar Weems (delegates); Drs. Ed Hill; Stanley Hill and Carl Evers (alternate delegates). C.L.M.

COMMENT**Abusing Rast:
An Increasing Problem**

The Radioallergosorbent Test (Rast) has been in use for about 14 years. It measures in vitro IgE antibodies. It has been helpful in research in allergy and useful in clinical application.

Adinson,¹ listed three forms of Rast abuse: (1) user abuse, (2) commercial abuse, and (3) abuses due to unvalidated interpretations of Rast results.

He points out abuse by physicians inexperienced in IgE mediated diseases who are poorly prepared to interpret the results. The Mississippi Allergy Clinic

has been asked by patients to explain how you can "diagnose allergy by drawing blood." Inquiry has shown that some physicians are actually telling patients that this can be done, and worse, are doing this.

Skin tests remain at present the most sensitive and least expensive way to evaluate the state of IgE mediated disease in allergic patients.

While the taking of a detailed allergic history and the examination of an allergic patient is both time consuming and necessary, it remains the most reliable way to evaluate and treat allergic patients. It is a rare indication to diagnose and treat on the basis of Rast alone.

Commercial abuse occurs with laboratories who claim to have Rast to detect IgE antibodies against some foods and drugs that are yet to be proven IgE mediated.

The abuse due to unvalidated interpretation of Rast results is resulting in some cases of inappropriate antigen therapy given to patients. Often they contain antigens that are not appropriate. Giving patients antigens they are not sensitive to may induce clinical sensitivity.²

Wittig and Blaiss³ compared the results of clinical history, skin testing and Rast scores in 274 patients seen in an allergy clinic. Using nine different antigens, they found that more than 90% of the patients who had reported clinical allergy to pollens had a positive skin test to the respective allergens. Only two-thirds had a positive Rast test. Only one had a positive Rast test and negative skin test. They concluded that Rast tests offer little or no advantage over skin testing for pollen allergies. Rast is certainly more expensive. Adinson⁴ states that the Rast is not yet a cost effective alternative to carefully performed skin tests for evaluation of IgE mediated disease.

We are concerned. The American Academy of Allergy and Immunology Standards Committee issued a position statement on skin testing and Radioallergosorbent testing (Rast) for diagnosis of specific allergens responsible for IgE mediated disease in July of 1982. It was subsequently reviewed

Awake with allergies

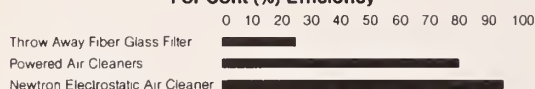


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COMMENT / Continued

and revised in September of 1982 and further reviewed and revised in November and December of 1982. I would like to quote in part from this position paper.

Section F: In reference to the comparative merits of skin tests and Rast for routine diagnosis of specific allergens responsible for IgE mediated disease the following statements are considered to be basically correct at this time:

- (1) Optimally performed skin tests and Rast both detect IgE antibody accurately and reproducibly.
- (2) Within the constraints of each method, both skin tests and Rast yield information of a semi-quantitative nature but Rast is less sensitive than skin test.
- (3) The results of skin tests are more immediately available. Where both tests can be initiated at the time of a patient's visit, the results of skin tests are available in about 45 minutes; those of Rast are available in two to three days.
- (4) Rast is preferable to skin tests in certain conditions where skin testing is unsatisfactory, particularly where there is dermatography or widespread skin disease.
- (5) Skin tests are usually more cost effective than Rast. Based on skin tests and Rast charges from sources participating in analysis, Rast cost two to six times more than skin tests per allergen tested.

The diagnosis of the allergic state is simple. The determination of the allergens responsible for the disorder is not simple. The treatment can be most complex and certainly involves more than "allergy shots."

WILFRED Q. COLE, M.D.
940 North State St.
Jackson, MS 39201

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2. Turketaub, P. L., Marsh, D. G., Lichenstein, L. M., Norman, P. S.: Development of long lasting immediate hypersensitivity in non-atopic volunteers perennially immunized with a purified grass pollen extract. *J. All. and Clin. Immunol.* 61:171, 1978.
3. Wittig, Heinz J. and Blaiss, Michael S.: How helpful is the radioallergosorbent test in the diagnosis of allergic disease? *S. Med. J.* 70:75, 820, 1982.
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MEDICAL ORGANIZATION

Dr. Virginia Tolbert Named to Prison Board

Dr. Virginia Tolbert of Ruleville, former director of the medical center at the Mississippi State Penitentiary, has been appointed to the state Board of Corrections by Gov. William Winter.

Dr. Tolbert served as medical director of the Parchman facility from 1979 to 1982. She resigned the post because limited budget forced a shortage of staff, supplies and other assistance.

Recently Dr. Tolbert, a member of the MSMA Board of Trustees, discussed her appointment and identified some of the concerns that the corrections board has. She said her role on the board is to supply medical expertise particularly, "but I am interested in Parchman and the corrections system generally."

Decentralization is one issue which the board faces. "I feel very strongly that Sunflower County cannot hold more," she said concerning the need to establish other facilities in the state to house prisoners. Dr. Tolbert pointed out the difficulty in attracting adequate staff for the Parchman facility due to its location in the remote, rural area. "Being local, I hope I can have more input as the board seeks to decentralize," she stated. "Since I have always lived close to Parchman I feel that I have interest in the problems here."

Problems at Parchman and the state's corrections system are ever-growing, she observed, and it will be important for the state to decide which directions it will take toward solutions and to spend the money necessary.

Dr. Tolbert also said she would like to see more efforts at rehabilitation of prisoners. She stated that from an economics standpoint, "we need to promote more job training in order to reduce recidivism."

Medical care is an important part of corrections work, Dr. Tolbert said. She identified the need to authorize a post and adequate salary for another physician on staff at Parchman. Currently there are three limited institutional license physicians on the staff to assist Dr. Dave Newton, medical director. She pointed to extraordinary demands on the Parchman medical director's time by attorneys, courts and other parties, and she said there is "a real need" for an additional qualified physician at the facility.

Philadelphia Doctor Cited By Medical Licensure Board

The Mississippi State Board of Medical Licensure has cited a Philadelphia doctor for unethical behavior and ordered him to stop making claims for an arthritis treatment and prescribing by mail.

The board ordered the license of Dr. Jasper M. Blount suspended, but stayed that order on the condition that he stop extolling the virtues of the treatment, stop prescribing for people he hasn't examined, and tell prospective patients that the treatment is experimental.

Dr. Blount, who has prescribed through the mail such drugs as Flagyl, Deltasone and Allopurinol, said he first discovered the methods when he successfully treated his own arthritis six years ago.

A board spokesman said it was not the type of drugs that was questioned as much as the way Dr. Blount prescribed them, and noted that his basic methods of treating rheumatoid diseases were in question.

The Board found Blount guilty of "unprofessional conduct, of dishonorable or unethical conduct likely to deceive, defraud, or harm the public, and making flamboyant claims concerning his professional excellence."

Auxiliary Announces Fall Workshop Agenda

"Auxiliary in Action" is the theme of the 16th annual fall workshop of the MSMA Auxiliary, scheduled for October 25 at the Jackson Regency Hotel.

Luncheon speaker will be Timothy R. Gompf, executive director of River Oaks Hospital, who will discuss "Doctors vs Hospitals . . . The Impact of Medicare Reimbursement."

Workshop topics include child abuse, public relations, MPAC and AMPAC, tips for auxiliary leadership, malpractice in Mississippi, critical television viewing skills, organ donation, and children of alcoholics.

Physicians and spouses are invited to attend the sessions. The registration fee of \$15.00 includes lunch. For more information, please contact Mrs. Terrell Blanton, 205 Hand Drive, Brandon, MS 39042.

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Employment Opportunity Day for Health Related Professions

The School of Health Related Professions at the University of Mississippi Medical Center will sponsor an Employment Opportunity Day from 10:00 a.m. until noon on Friday, December 2, in the School of Nursing auditorium.

Employers from Mississippi and surrounding states are invited to meet with the school's graduating students in cytotechnology, dental hygiene, medical record administration, medical technology, nurse anesthesia, physical therapy and respiratory therapy.

Because space is limited, interested employers must register in advance by calling (601) 987-5942.

This event is only one of several planned during this December 2-3 celebration of the School of Health Related Professions' ten years of service to the state. On tap are continuing education programs for health professionals, class reunions, alumni meetings, a dinner and dance and an open house in the School. For further information, call (601) 987-4914 or write Continuing Health Professional Education, 2500 North State Street, Jackson, MS 39216.

Thoracic Society Announces Agenda for Annual Session

The Mississippi Lung Association and the University of Mississippi Medical Center are co-sponsoring the Mississippi Thoracic Society's annual session November 3 in Jackson.

The session will be held on the Medical Center campus in the Oglevee Building. Parking will be available in the Mississippi Memorial Stadium parking lot, with shuttlebus service provided to the campus.

The program begins with registration and coffee at 9:00 a.m. Scientific sessions begin at 9:30 a.m. Dr. A. W. Conerly will preside. Speakers include Drs. Watts R. Webb of New Orleans, and John Studdard, William C. Pinkston, and Roy D. Wilson, all of Jackson.

Topics include "Preoperative Assessment, Post-operative Care," presented by Dr. Wilson; "Thoracic Trauma — Medical and Surgical Implications," Dr. Webb; "Clinical Update: Adult Respiratory Distress Syndrome," Dr. Pinkston; and "Clinical Update: Sarcoidosis," Dr. Studdard.

The program meets the criteria for 5.2 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association and is acceptable for 5.2 prescribed hours by the American

Academy of Family Physicians. The Division of Continuing Health Professional Education will award .5 CEU for full attendance.

Registration fee of \$10.00 includes tuition, refreshment breaks, and lunch. Advance registration is requested. For more information contact the Continuing Health Professional Education, UMC, 2500 North State Street, Jackson, MS 39216; (601) 987-4914.

Symposium to Focus On Musculoskeletal Problems

"Common Musculoskeletal Problems Seen in Office Practice" is the topic of a symposium set for October 21 at the Forrest County General Hospital in Hattiesburg. The program is co-sponsored by the hospital and the Hattiesburg Clinic, P.A.

This one-day meeting is designed to provide primary care physicians with a review and update on the evaluation and management of common musculoskeletal problems. Topics to be discussed include: osteoarthritis and musculoskeletal pain syndromes, the painful shoulder, new approaches to disc disease, treatment of rheumatoid arthritis, commonly missed orthopedic diagnoses, infectious arthritis, and selected problems in pediatric orthopedics.

The program is approved for Class I continuing medical education credit by the AMA, and prescribed credit by the American Academy of Family Practice has been applied for.

For more information, contact the Hattiesburg Clinic, P.A., 415 South 28th Avenue, Hattiesburg, MS 39401.



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Medico-legal Brief

Patient Has Right to Choose Surgeon, Court Rules

A patient who consented to surgery by a specific surgeon and was operated on by another surgeon could sue the surgeon who did not operate for malpractice and the one who did operate for battery, the New Jersey Supreme Court ruled.

The patient consulted a urologist, and he recommended surgery for removal of kidney stones. Another physician from the same medical group as the urologist later met with the patient and explained that two members of the group would be present during the operation. The patient signed a consent form that named the urologist as the operating surgeon and authorized him to perform the operation with the aid of unnamed assistants.

The operation was performed by a third member of the group, and the urologist was not present. The patient first learned of the identities of the operating surgeons when he was readmitted to the hospital because of postoperative complications.

In a suit for malpractice against all three physicians, the patient alleged, among other things, lack of informed consent because his consent was based on his belief that the urologist would operate. The jury decided in favor of the physicians, and an appellate court affirmed.

The Supreme Court said that if an operation is properly performed, even though it is performed by a surgeon operating without the patient's consent, a jury could find that substitution of surgeons did not cause a compensable injury but could award damages for mental anguish resulting from the belated knowledge of the substitution. The court said that any nonconsensual touching is a battery. Further, even more private than the decision as to who may touch one's body is the decision as to who may cut it open and invade it with hands and instruments. In the absence of an emergency, the court said, a surgeon who operates without a patient's consent engages in unauthorized touching and thus commits a battery.

The court said that the action against the urologist stemmed from the alleged breach of his agreement to operate and the fiduciary duty owed to his patient. A patient has a right to know who will operate, and a consent form should reflect the patient's decision, the court said. Failure to perform an operation after soliciting a patient's consent is a deviation from standard medical care. Whether the right surgeon operates on the wrong part or the wrong surgeon operates on the right part of the patient, it is malprac-

tice, the court said, and in each instance the surgeon has breached his duty to care for the patient.

If damages result from deviation from standard medical care, a patient has a cause of action for malpractice. Reversing the lower courts' judgment, the court sent the case back for further proceedings. During these proceedings, the court stated that the possible bias of a member of the malpractice panel and the credibility of a witness before the panel was relevant. — *Perna v. Pirozzi*, 457 A.2d 431 (N.J.Sup.Ct., March 2, 1983)

NEW MEMBERS

CLARK, JAMES I., Natchez. Born Wayne County MI, Sept. 3, 1920; M.D., University of Michigan Medical School, Ann Arbor, 1950; interned Mercy Hospital, Des Moines, Iowa, one year; anatomic and clinical pathology residency, Butterworth Hospital, Grand Rapids, MI, 1960-64; elected by Homochitto Valley Medical Society.

FAISON, JOSEPH L., Gulfport. Born Fernandina Beach, FL, July 7, 1941; M.D., University of Michigan Medical School, Ann Arbor, 1974; medicine internship, U.S.A.F. Medical Center, Keesler AFB, MS, 1974-75; elected by Coast Counties Medical Society.

FELLOWS, WILLIAM RISLEY, Biloxi. Born Canada, March 17, 1930; M.D., Queen's University Medical School, Kingston, Ontario, Canada, 1955; interned Presbyterian Hospital, Chicago, one year; family medicine residency, Henry Ford Hospital, Detroit, 1956-60; elected by Coast Counties Medical Society.

HANS, OSVALDO, Corinth. Born Cordoba, Argentina, Sept. 7, 1946; M.D., National University of Cordoba, Argentina, 1970; interned Washington Hospital Center, Washington, DC, one year; ENT residency, St. Louis University Hospital, 1979-81; head and neck fellowship, same, 1981-82; elected by Northeast Mississippi Medical Society.

LOPEZ, RICARDO E., Gulfport. Born Republic of Panama, May 21, 1937; M.D., Tulane University School of Medicine, New Orleans, 1962; interned Detroit Memorial Hospital, Detroit, one year; internal medicine residency, Tulane Medical Center, New Orleans, 1981-82; elected by Coast Counties Medical Society.

MATTHEWS, CHRIS, V., Poplarville. Born Houston, TX, Sept. 20, 1954; M.D., Louisiana State University School of Medicine, New Orleans, 1980; family practice residency, Tallahassee Memorial Hospital, Tallahassee, FL, 1980-83; elected by Pearl River Medical Society.

SEARLE, CHARLES ROGER, Picayune. Born England, Jan. 30, 1946; M.D., University of Ottawa Faculty of Medicine, Ottawa, Ontario, Canada, 1976; interned Ottawa Civic Hospital, Ottawa, Ontario, Canada one year; elected by Pearl River Medical Society.

STUBBS, KENNETH W., Natchez. Born Baton Rouge, LA, April 16, 1953; M.D., Louisiana State University School of Medicine, New Orleans, 1979; interned Earl K. Long Hospital, Baton Rouge, one year; internal medicine residency, same, 1980-82; elected by Homochitto Valley Medical Society.

WEILAND, RICHARD C., JR., Gulfport. Born Clarksdale, MS, Aug. 26, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1980; interned and family medicine residency, University Medical Center, Jackson, 1980-83; elected by Coast Counties Medical Society.

Wood, Henry E., Jr., Gulfport. Born Sylacauga, AL, July 19, 1948; M.D., Louisiana State University School of Medicine, Shreveport, 1980; interned Eugene Talmadge Memorial Hospital, Augusta, GA, and Earl K. Long Memorial Hospital, Baton Rouge, one year; internal medicine residency, Earl K. Long Memorial Hospital, Baton Rouge, 1981-83; elected by Coast Counties Medical Society.

DEATHS

RUBISOFF, REUBEN, Clarksdale. Born Stanodub, Russia, May 1, 1910; M.D., University of Illinois College of Medicine, Chicago, 1937; interned Mt. Siani Hospital, Chicago, 1934-36; member of Clarksdale & Six Counties Medical Society; died August 19, 1983, age 73.

WADSWORTH, H. M., Hernando. Born Ripley, TN, June 30, 1911; M.D., University of Tennessee Center for Health Sciences, Memphis, 1935; interned Hotel Dieu Hospital, New Orleans, one year; member of Desoto County Medical Society; died August 15, 1983, age 72.

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

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The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used IV: inject slowly, taking at least one minute for each 5 mg (1 ml) given, do not use small veins, i.e., dorsum of hand or wrist, use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly IV, it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation (initially 2 to 2½ mg once or twice daily; increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity,

insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoaesthesia, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL: Adults: Anxiety disorders, relief of symptoms of anxiety—**Valium** (diazepam/Roche) **tablets**, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 **Valrelease capsules** (15 to 30 mg) daily. Acute alcohol withdrawal—**tablets**, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 **capsules** (30 mg) the first 24 hours, then 1 **capsule** (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—**tablets**, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 **capsules** (15 to 30 mg) once daily. Adjunctively in convulsive disorders—**tablets**, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 **capsules** (15 to 30 mg) once daily.

Geriatric or debilitated patients: **Tablets**—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). **Capsules**—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: **Tablets**—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). **Capsules**—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.) For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly IV, it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, **in adults**, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); **in children** administer I.V. slowly; for tetanus **in infants** over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; **in children 5 years or older**, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg **adult** dose administered slowly; repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary; keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. **Infants (over 30 days)** and **children (under 5 years)**, 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). **Children 5 years plus**, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful. In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levorotatory or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL: Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (dispensable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.



PERSONALS

JAMES L. ACHORD of UMC recently was in Bethesda, Maryland, to serve as a member of a planning group for the National Digestive Diseases Advisory Board of the National Institutes of Health.

LARRY AYCOCK of McComb recently spoke to the McComb Rotary Club on the subject of cancer.

GEORGE BALL of Jackson has been elected to the Board of Directors of the Bank of Jackson.

JOHN M. BEAMAN announces the opening of the Perry County Family Care Clinic at 306 Bay Street in Richton.

RUSSELL E. BELENCHIA has associated with Laird Clinic in Union for the practice of family medicine.

A. WALLACE CONERLY of UMC was a speaker at the Tri-State Respiratory Therapy Conference in Biloxi.

C. E. GUICE, III, has associated with The Hattiesburg Clinic for the practice of otolaryngology, head and neck surgery, facial plastic surgery, and ear, nose and throat allergy.

JAMES HARDY of UMC has been inducted into honorary fellowship of the Royal College of Surgeons in London, England.

MARTIN B. HARTHCOCK of Jackson recently participated in a seminar on plastic surgery at U.S. Naval Hospital/Letterman General Hospital in Oakland, California.

ROBERT B. IRWIN announces the opening of his office for the practice of allergy at 516 Pegram Drive in Tupelo.

MICHAEL E. JABALEY of Jackson recently was principal speaker at the annual meeting of the South African Hand Society at Bloemfontein, South Africa. He also visited training centers in Capetown, Durban, and Johannesburg, where he lectured to plastic and orthopedic surgeons and trainees on several aspects of hand surgery.

CHARLES JOHNSON announces the opening of his office for the practice of obstetrics and gynecology at 914 Sumrall Road in Columbia.

VICTOR E. LANDRY of Lucedale has been selected as one of twenty American physicians who will tour the People's Republic of China as part of an emergency medicine and trauma care delegation.

J. P. LEE and W. M. LEWIS of Forest announce the association of A. A. HOWARD in the practice of family medicine at Forest Family Practice Clinic, 285 First Street.

JOHN R. LOVELACE of Batesville, president of the Board of Trustees, Institutions of Higher Learning, delivered the commencement address at Mississippi State University in August.

ELDON D. McCLAIN of Biloxi presented an update on AIDS for employees of Biloxi Regional Medical Center and the public.

C. A. MARASCALCO of Vicksburg recently attended a Medical College of Georgia course in cardiac and pulmonary critical care medicine at Kiawah Island, South Carolina.

W. BOYD MASSEY of Jackson announces the association of MICKEY P. WALLACE for the practice of ear, nose and throat surgery and facial plastic surgery.

JOHN C. MORRISON of UMC recently was lecturer at Keesler Air Force Base in Biloxi.

ED NORTH of Jackson recently was inducted into the national Exchange Club Hall of Fame.

PATRICK PIERCE of Gulfport has been re-elected vice chairman of the Mississippi Health Care Commission.

GEORGE D. PURVIS was inducted into membership of the American Orthopaedic Association recently, and presented a paper during the organization's annual meeting.

MICHEL E. RIVLIN of UMC made a poster presentation at the 23rd British Congress of Obstetrics and Gynecology in Birmingham, England.

GUS A. RUSH, III, of Meridian has been named to the 1983 edition of *Outstanding Young Men of America*.

CLIFFORD A. SEYLER of Pascagoula announces the association of CATHY A. BUTTS in the practice of pediatrics at Doctors Plaza, 4211 Hospital Road.

JERRY L. STENNETT announces the opening of his office for the practice of general, thoracic and vascular surgery.

ADDISON T. TATUM of Petal announces the association of NANCY O. TATUM for the practice of family medicine.

B. SCHEDELL WALLEY has associated with Walley's Clinic, P.A., of Waynesboro, for the practice of general medicine.

PERSONALS / Continued

GLEN C. WARREN of Jackson announces the relocation of his office for the practice of neurological surgery to 10 Lakeland Circle.

The President Speaking

(Continued from page 280)

the diagnosis of Peptic Ulcer with hemorrhage on the chart front. If this happens, then in the next year or two, another patient comes in and requires two weeks hospitalization or surgery. That same surgeon can expect to receive pay for only four to five days of hospitalization.

The hospitals will also keep DRG quotients on individual doctors. Already, in New Jersey, some doctors are being refused hospital staff privileges and are being stopped from doing certain procedures because of their profiles.

There is no question that over the next four years, things are going to get progressively tougher for the hospitals, and they will be looking for new sources of income. C. R. Rorem, the organizer of the Blue Cross Commission, was quoted in *Hospitals*, January 1, 1983, "medical care is too important to be left completely in the hands of doctors. Physicians should either own a hospital or be employed by one." Also, already Senator Durrenburger is saying that the government will group the hospital and doctor payments together. As the dinner-dance progresses, expect to be courted by hospitals so that they can serve their own alphabet soup courses in the way of HMOs, PPOs, and OP departments.

Bachelorhood may be tough and marriage may look pleasant; but I for one, am not ready to lose my independence to crawl into the hospital's bed for life just for accepting an invitation to come to dinner.

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

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Before prescribing, see complete prescribing information. The following is a brief summary.

DESCRIPTION: Each sustained release capsule contains 12 mg of Chlorpheniramine Maleate, USP and 75 mg of Phenylpropanolamine Hydrochloride, USP in a base to provide prolonged activity.

INDICATIONS: For the treatment of the symptoms of seasonal and perennial allergic rhinitis and vasomotor rhinitis, including nasal obstruction (congestion).

CONTRAINDICATIONS: Hypersensitivity to any of the components, concurrent MAO inhibitor therapy, severe hypertension, bronchial asthma, coronary artery disease, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. Do not use in children under 12 years.

Do not use this drug in patients with narrow-angle glaucoma, obstructive or paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. Do not use in nursing mothers.

Use in treating lower respiratory tract symptoms, including asthma, is contraindicated.

WARNINGS: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients. Patients should also be warned about the possible additive effects of alcohol and other CNS depressants.

Usage in pregnancy: Safe use in pregnancy has not been established. Use only when the potential benefits have been weighed against the possible hazards to the mother and child. Note that an inhibitory effect on lactation may occur.

PRECAUTIONS: Use with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension, hiatal hernia with reflux esophagitis, intestinal atony of the elderly or debilitated patient, myasthenia gravis, renal function impairment, and ulcerative colitis (severe).

Drug Interactions: MAO inhibitors, Alcohol or CNS depressants, especially anesthetics, barbiturates, and narcotics.

ADVERSE REACTIONS: Prolongs the response to nervous stimulation, potentiates the response to norepinephrine, and inhibits the response to tyramine.

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Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesia, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteresis, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

DOSAGE AND ADMINISTRATION: Dosage should be individualized according to the needs and response of the patient. Adults: one capsule every 8 to 12 hours not to exceed 3 capsules daily. Not for use in children under 12 years of age.

OVERDOSAGE: Treatment of the signs and symptoms of overdosage is symptomatic and supportive. In the event of overdosage, emergency treatment should be started immediately.

Treatment: The patient should be induced to vomit, even if emesis has occurred spontaneously. Vomiting by the administration of ipecac syrup is a preferred method. However, vomiting should not be induced in patients with impaired consciousness. Stimulants (analeptic agents) should not be used. Vasopressors may be used to treat hypotension. Short-acting barbiturates, diazepam or paraldehyde may be administered to control seizures. Hyperpyrexia, especially in children, may require treatment with tepid water sponge baths or a hypothermic blanket. Apnea is treated with ventilatory support.

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ANESTHESIOLOGIST seeks to relocate in state in solo, group or institutional practice. Contact M. T. Olivo, Jr., M.D., Box 794, Oxford, MS 38655.

PATHOLOGIST seeks location in Mississippi. M.D., Ohio State University; residency, University of Alabama. Contact Janice Blazina, M.D., 2323 DeLee St., Apt. 31, Bryan, TX 77801.

BOARD CERTIFIED FAMILY PRACTITIONER seeks location in Jackson or Greenville area with established group beginning August 1, 1984. Contact Hernando C. Payne, M.D., 1557-A Eglin Way, Washington, DC 20336.

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FAMILY PRACTITIONER wanted to locate in East Central Mississippi community, population 1,000 with trade area of 10,000. Clinic will be provided if desired. Contact Sandersville Health Care Services, Inc., Drawer C, Sandersville, MS 39477.

FAMILY PRACTITIONERS. Excellent private practice opportunity, well equipped 30-bed hospital in operation less than two years. Office space available in renovated clinic, 100-bed nursing home, nice community, good schools and recreational facilities, located 30 miles east of Jackson. Call (601) 732-6252 or write A. B. Farris, Jr., Mayor, P. O. Drawer 338, Morton, MS 39117.

FAMILY PHYSICIAN wanted to locate in small town in central Mississippi. Excellent private practice opportunity. Large trade area. Established clinic with all equipment, including x-ray. Call (601) 253-2321. Mayor Grady Sims, Walnut Grove, MS 39189.

FAMILY PRACTITIONER for historic Vaiden, MS. Population 1,000 with outlying area of 1,200. Located on I-55 between Jackson, MS and Memphis, TN. Ideal free office adjoining dental clinic. Our beloved physician retired. Lucrative practice, no competition; outstanding hospital (10 miles). Friendly community; fine public schools; family-like churches. Excellent housing; low taxes; hunting, fishing and trapping galore. For more details call (601) 464-8884 or write John C. Coleman, Mayor, P.O. Box 76, Vaiden, MS 39176.

FAMILY PRACTITIONER, surgeon and ob-gyn to locate with established practice in south Mississippi. Salary negotiable, partnership arrangement. Write Box A-115, Journal MSMA, P.O. Box 5229, Jackson, MS 39216.

ESTABLISHED GENERAL PRACTICE for sale or rent. Fully equipped, located at Southland Plaza, Louisville, MS. Contact David Wilson, Jr., P.O. Box 205, Louisville, MS 39339; telephone (601) 773-6052.

FULLY EQUIPPED ob-gyn clinic available for immediate occupancy. Trade area of approximately 50,000 persons; modern hospital; no other obstetricians in immediate area. Contact Mr. James Townsend, Administrator, Bolivar County Hospital, Cleveland, MS 38732, or call (601) 846-2550.

COMMUNITY seeks family or general practitioner. Building available for clinic, and county hospital within 10 miles. Contact Bo Robinson, Rt. 1, Box 190, Hamilton, MS 38746 or call (601) 343-8924 at night.

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IN CONCLUSION

For the first time in 17 years, enrollment of first year medical students has decreased, according to the September 23 issue of JAMA. The reduction, down 90 students from last year's enrollment, is partly due to cutbacks of medical school subsidies by states and also to some medical schools switching from three to four year programs. The issue is devoted to a survey of medical education in the U.S., the 83rd such annual report. The issue also reports that the number of medical school applicants in 1982-83 decreased by 1,000 (2.7%).

A proposed FDA rule would clarify that a physician may prescribe an approved drug for uses not included in the drug's approved labeling. Once a drug has been approved for marketing, a physician may prescribe it for a non-approved purpose in treating patients. The FDA's announced goal is to encourage innovation by narrowing the scope of regulation. The AMA, long concerned with the role of regulations in the so-called "drug lag," supports the FDA's policy goals and most of the specific changes recommended.

TEFRA regulations deprive clinical pathologists of the right to practice medicine, the AMA said in an amicus curiae brief in support of a suit brought by the College of American Pathologists. The brief argued that regulations to implement the Tax Equity and Fiscal Responsibility Act of 1982 include an arbitrary definition of the practice of medicine. As written, the regulations provide that a clinical pathologist is not engaged in the practice of medicine when he performs clinical laboratory procedures. The regs also restrict a pathologist's role as consultant.

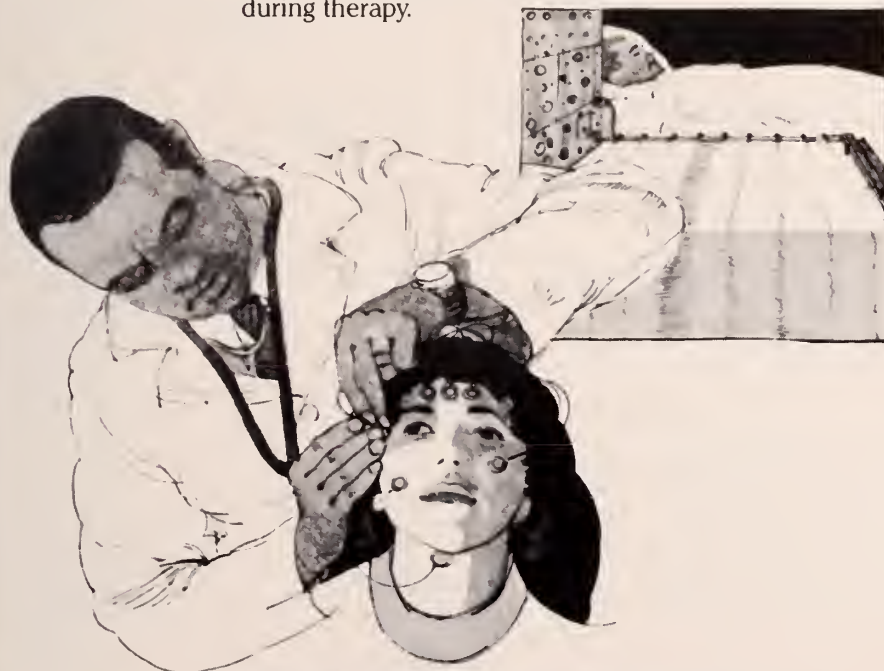
Multiple sclerosis with few or no symptoms may occur as often as diagnosed MS, according to a report in the September issue of Archives of Neurology. Because sophisticated diagnostic methods have made it easier to diagnose MS, more people with minimal disease may be identified, the authors say. Their study found unsuspected MS in patients autopsied after deaths from other causes. They warn against extending an "unduly pessimistic perception of MS" to the patients with benign disease.

"Child health care providers might communicate more effectively with their patients if they become more familiar with typical stages of children's understanding of illness concepts," say authors writing in the American Journal of Diseases of Children. When asked to estimate children's ages by their answers to questions about the cause, prevention and treatment of illness, a group of physicians and nurses generally overestimated the understanding of young children and underestimated that of older children, their study found.

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References: 1. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 4. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 5. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Kales JD: *Pharmacol Physicians* 4:1-6, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5:25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The

sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. **Adults:** 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

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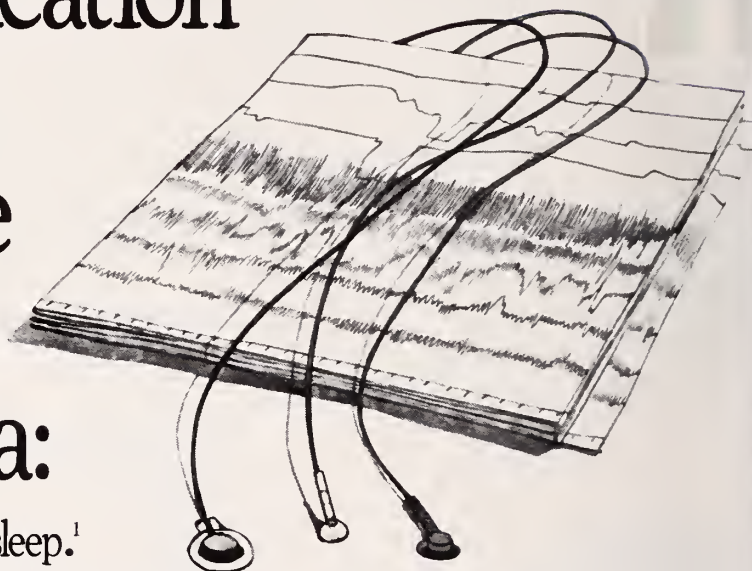
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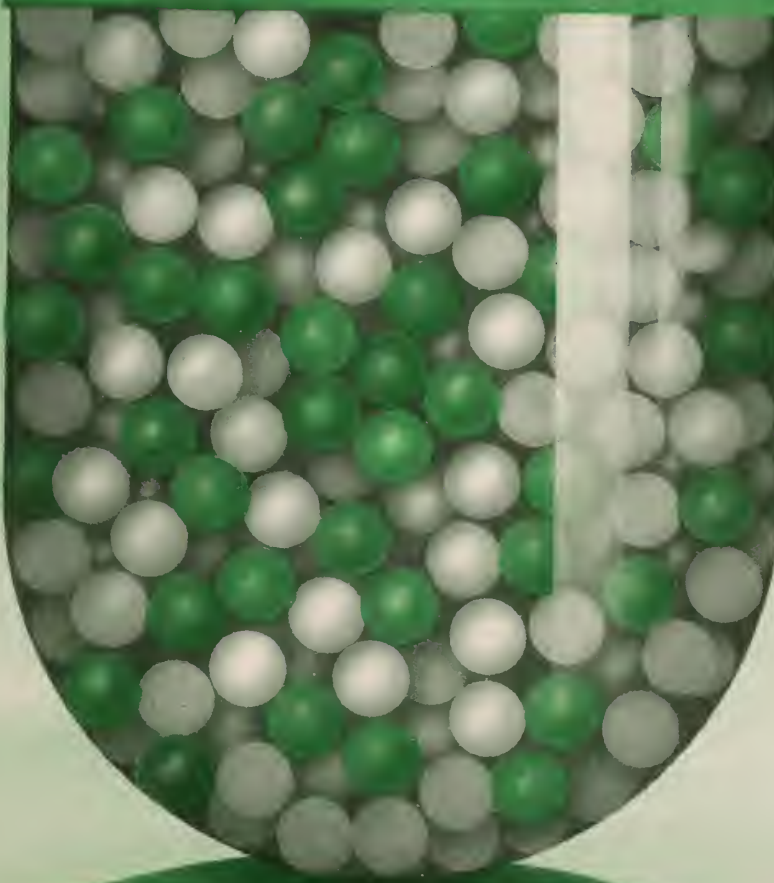
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NEWSLETTER

November 1983

Dear Doctor:

A proposal to roll back and freeze for six months Medicare payments to physicians and to require physicians to accept assignment of all Medicare claims for inpatient services has been rejected by the House Ways and Means Committee, after winning approval of the health subcommittee. But Committee chairman Rep. Dan Rostenkowski has stated his intention to take the proposal to the House floor.

The freeze would reduce the number of physicians who participate in Medicare, said AMA President Frank J. Jirka, Jr., M.D., early last month. He noted the result would be a loss of choices for the elderly.

"Dictating mandatory assignment is a break with the original Medicare promise of 1965," he added.

There are no federal regulations to prohibit a Virginia physician from carrying through with his plans to establish a company that would arrange for donors world-wide to sell one of their kidneys, according to recent news reports.

The physician, whose license to practice in Virginia was revoked after a 1977 mail fraud conviction involving Medicaid and Medicare, plans to charge \$2,000 to \$5,000 for his service as broker, with donors setting a price for their kidneys. A bill introduced in August by U. S. Rep. Albert Gore would prohibit the sale of human organs. Gore heads a subcommittee investigating new and disturbing developments in the sale of organs for transplant operations.

The Social Security Advisory Council has reversed an earlier decision and now advocates a limitation on the amount of employer-paid health insurance premiums that an employee may receive tax-free. The Council endorsed caps set at \$175 for family plans and \$70 for individuals -- limits identical to those proposed by the Reagan Administration earlier this year. At its September meeting the Council also voted to recommend increasing the age of eligibility for Medicare to age 67 beginning in January 1986.

The Arthritis Information Clearinghouse has announced three new publications, including a "Directory of Information Resources" to provide quick references for physicians, nurses, therapists, educators, and librarians. The other two publications are "Juvenile Arthritis - An Annotated Bibliography" and "Juvenile Arthritis Parent Education." All are available at no charge from the Arthritis Information Clearinghouse, P.O. Box 9782, Arlington, VA 22209.

Sincerely,



Patsy Silver
Managing Editor

MEETINGS

National and Regional

American Medical Association, Annual Meeting, June 17-21, 1984, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610

State and Local

Mississippi State Medical Association, 116th Annual Session, May 16-20, 1984, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Mississippi Academy of Family Physicians, Annual Meeting, June 13-17, 1984, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39221.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, October, December, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, January, May, and November. H. S. Barrett, Secy., P.O. Box 1810, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Charles L. Wilkinson, Secy., Mail: Ms. Jenkins, 1415 50th Ave., Meridian 39301. Counties: Clark, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1488, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Richard C. Carter, Pres. and Secy., 314 W. Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. Roger L. Lowery, Secy., 618 Pegram Dr., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Steve Parvin, Secy., 816 Second Ave. North, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, June, September, December. S. B. Fineberg, Sec'y., 2204 Old Mobile Hwy., Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.


South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Pendergrass, Secy., 201 Hospital Dr., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Maxwell's Restaurant, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly Mississippi State Medical Association 735 Riverside Drive Jackson, MS 39216	Northwest Mississippi Regional Medical Center Box 1218 Clarksdale, MS 38614
North Mississippi Medical Center 830 Gloster Avenue Tupelo, MS 38801	Mississippi Chapter American College of Surgeons Box 5229 Jackson, MS 39216
Forrest General Hospital Box 1897 Hattiesburg, MS 39401	Mercy Regional Medical Center 100 McAuley Drive Vicksburg, MS 39180
Mississippi Baptist Hospital 1225 N. State Street Jackson, MS 39201	North Panola County Hospital Drawer 160 Sardis, MS 38666
Gulf Coast Community Hospital 4642 W. Beach Boulevard Biloxi, MS 39531	Singing River Hospital 2809 Denny Avenue Pascagoula, MS 39567
Jefferson Davis Memorial Hospital Box 1488 Natchez, MS 39120	Magnolia Hospital Alcorn Drive Corinth, MS 38834
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DATELINE

Health Issues Jackson, MS - A number of topics are on the agenda for
Seminar Scheduled MSMA's 3rd Annual Health Issues Seminar. Speakers will
explore such subjects as "Physicians and DRG Reimburse-
ment," "How to Develop a PPO, IPA, or HMO," "The Training and Licensing of
Physicians in Mississippi," and "Hospital-Medical Staff Relationships." The
event is scheduled for March 3 in Jackson. A banquet on Friday night, March 2,
will kick off the seminar. Sen. Thad Cochran will be the keynote speaker.

AMA Says Abolish Chicago, IL - The conventional insanity defense has
Insanity Defense outlived its usefulness, the AMA Committee on Medico-
legal Problems said in a report that will be transmitted
to the House of Delegates. In approving the report, the AMA Board recommended
adoption of a new policy calling for abolition of the special defense for
insanity. The existing doctrine invites abuse, confuses juries, and impedes
efforts to provide treatment to mentally ill offenders, the report concluded.

1981 Hospitalization Hyattsville, MD - Average length of stay of the 38.5
Utilization Report million Americans hospitalized in 1981 was 7.2 days,
according to a report from the National Center for
Health Statistics. Discharges from short-stay hospitals by geographic region
ranged from 6.4 million in the West to 13.2 million in the South. Average stay
for both sexes was about the same. Diseases of the circulatory system were
principal diagnoses, followed by diseases of the digestive system.

Viral Cultures Miami, FL - A medical virologist at the National
For Dx of Herpes Institute of Allergy and Infectious Diseases urged
family physicians to perform viral cultures to con-
firm the diagnosis on all patients suspected of having herpes. He was among
those addressing a special symposium sponsored by the American Academy of Family
Physicians on management of herpes and AIDS. Misdiagnosis is possible, he said,
if the patient comes in at a time when lesions are not at most familiar stage.

Lowest Increase Washington, DC - The consumer price index rose at
Yet for MD Services an annualized rate of 4.1% during August. The overall
rate of inflation averaged 2.6% for the last 12
months, down from 5.9% for the previous 12-month period. The physicians'
services component rose at an annualized rate of 3.4%, its lowest rate of
increase this year. The hospital room component rose during August at an
annualized rate of 17.8%.

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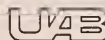
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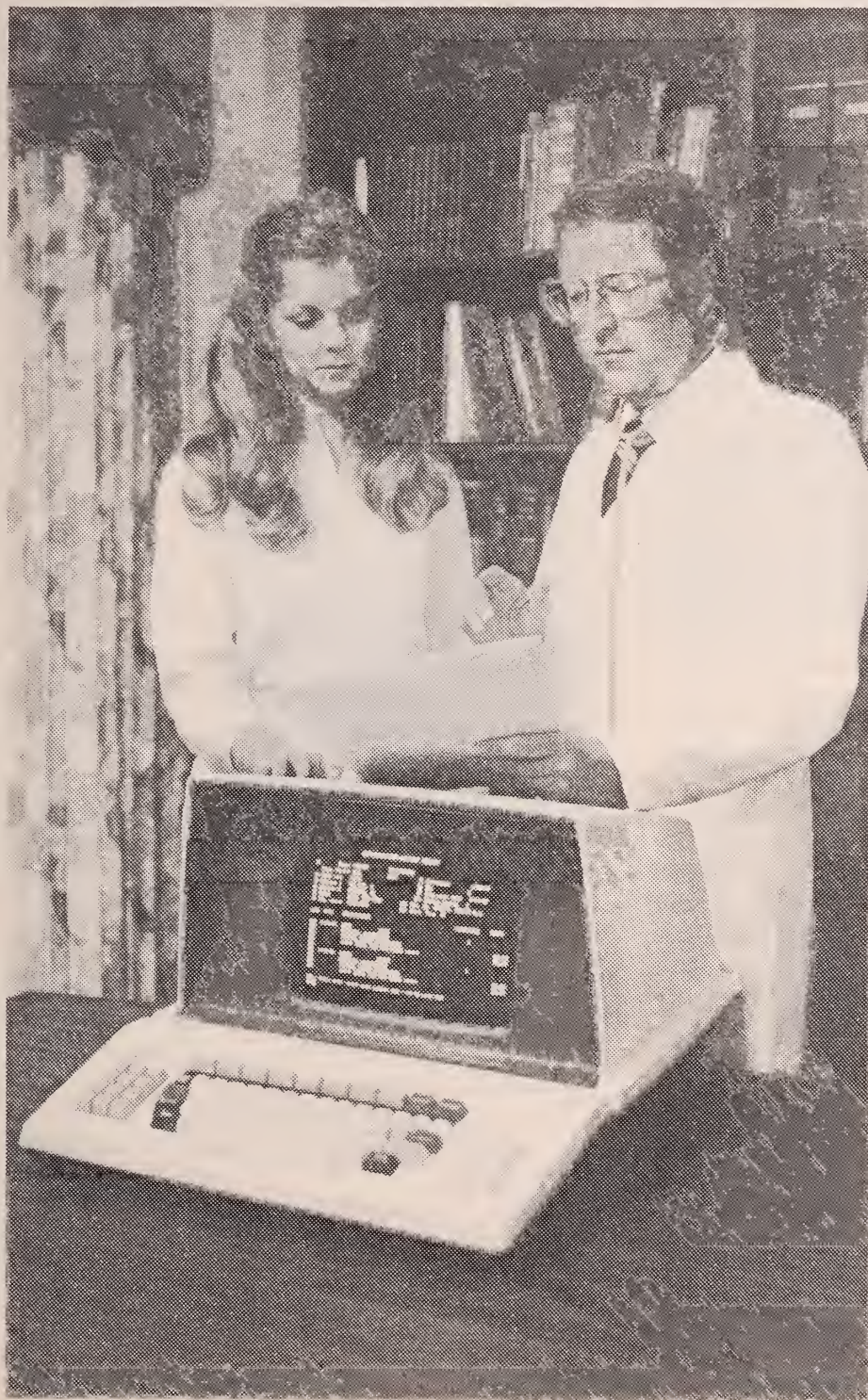
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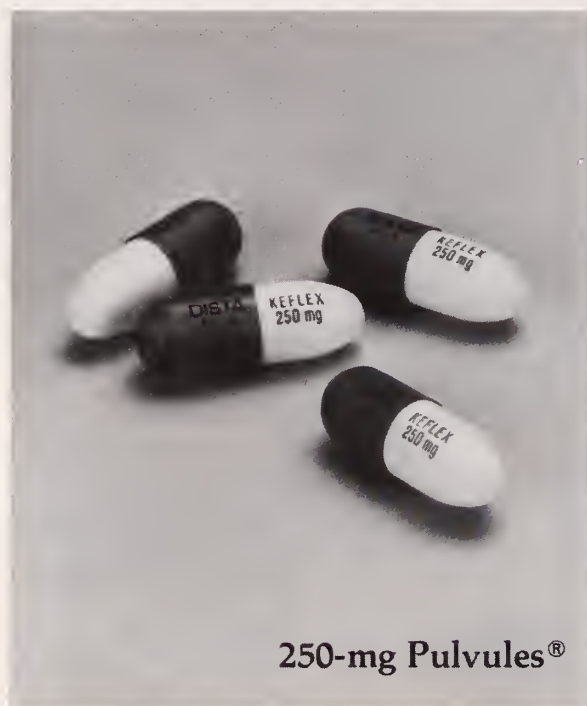
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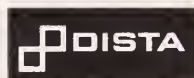
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ORIGINAL PAPERS

Technologic Advances in Ambulatory Obstetrics and Gynecology: Boon or Bane?

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Jackson, Mississippi

MOST CHANGES in health care during the past 20 years have evolved because we are immersed in a rapidly developing technologic society. No area of medicine is pursuing new modalities more rapidly than obstetrics and gynecology, particularly in the ambulatory area. Though many positive effects on health care in our field have been accrued, advances in technology must be carefully evaluated by weighing the benefits and risks prior to applying new methodology. These decisions often are not easy. Information gleaned from fetal health assessment tests in the office may show fetal compromise and dictate that the pregnancy should be terminated. On the other hand, the neonate may succumb to Respiratory Distress Syndrome due to lung immaturity from early iatrogenic delivery. As health care providers, we must combine these new innovations in technology with our clinical experience to avoid losing the "art" of medicine. Many opponents on the "new technology" also argue that we are depersonalizing or dehumanizing health care by utilizing machines, thus decreasing personal involvement with our patients. In this article a moderate approach is advocated as it concerns the consideration of technologic advances.

Specific advances in assessment "risking" of the

prenatal patient in the ambulatory setting have been noninvasive and effective and have yielded historic and physical information of great benefit. The use of risk assessment tools, such as the Hollister Record System, in all antenatal patients aids in complete evaluation of the women as well as providing a common communication avenue between health care providers. Routine prenatal laboratory screening identifies common medical disorders early which may require intervention or close follow-up. These routine laboratory assessments are recommended for all antepartal patients and include: hemoglobin/hematocrit, type, Rh and antibody screen, serology, rubella titer, pap smear, GC and urine mini-cultures, as well as glucose assessment (2 hour post prandial plasma glucose). In contrast there does not seem to be a distinct advantage in obtaining routine chest x-rays, TB skin tests, or TORCH titers. The yield from these latter tests has not been cost effective nor has it positively impacted on the care rendered the patient. Therefore, they should be reserved for the individual case where such testing is indicated. In general, intensive routine surveillance in each antepartum patient enables one to identify 75% of all subjects who have or will develop risk factors during that gestation, a most laudable and cost effective objective. One must not forget, however, that 25% of patients who are assessed as "normal" during the antepartum period will become high risk during labor or postpartum period.

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Assessment of the fetus in high risk pregnancies has been greatly enhanced through such procedures as amniocentesis, ultrasonography, nonstress (NST) testing, and contraction stress testing (CST). Amniocentesis is used early in pregnancy to detect genetic abnormalities as well as other congenital anomalies and later in gestation to monitor the progression of maternal/fetal disease or evaluate lung maturation. It provides the physician and patient optimal information on which to base intervention and therapeutic decisions. Real time ultrasonography (USG) in the ambulatory setting offers a wealth of information such as assisting in gestational age assessment, localization of placenta (and amniotic fluid) to assist in performing amniocentesis, and verification of cardiac motion to confirm viability. This modality in an office setting is not sensitive enough, however, to detect growth retardation, fetal anomalies or to define marginal placenta implantation. The routine USG for all parturients is not recommended because it is not cost effective and the long term fetal effects of ultrasound are unknown. The NST and CST provide information about fetal cardiac reactivity associated with fetal movements and placental "reserve," respectively. Utilization of these tests allows the provider to assess fetal health in those patients with medical complications such as diabetes, chronic hypertension, etc. These tests can be utilized in ambulatory settings and assist the clinician in predicting an optimal delivery time when threatened by potential fetal compromise. Prior to employment of such testing procedures many pregnancies were delivered prematurely, resulting in nursery management dilemmas for the pediatrician. Currently, by using risk assessment, fetal health assessment, maturity studies and clinical acumen, an optimal delivery time can usually be chosen that is best for both mother and fetus.

Advances in Ambulatory Gynecology

There have also been advances in the area of ambulatory gynecology. The use of cryosurgery has enabled us to treat non-malignant cervicitis which so frequently plagued practitioners and consumers. It is now used to treat premalignant disorders such as dysplasia and carcinoma in situ, although this therapy is controversial because of purported increases in recurrence of the disease. Nevertheless, the use of cryosurgery as an ambulatory technique is an important portion of the gynecologist's armamentarium.

The use of the colposcope is another methodology in ambulatory gynecology that has enjoyed a resurgence of interest. Long advocated in Europe, American gynecologists are using this modality to selec-

tively biopsy abnormal epithelium of the cervix and vagina. It has been extremely helpful in avoiding random biopsy in the cervix which may lead to nonspecific diagnoses in many cases. Also, conization can be avoided in other cases, and the destruction of the cervix with subsequent interference in childbearing can be obviated. Gynecologic urologic modalities such as the cystoscopy have also found favor in the last decade in the ambulatory gynecologist's office. Particularly in the evaluation of female urinary incontinence the use of office cystoscopy is increasing. Although the CO₂ laser is being used more frequently, its great expense makes it usually found within the hospital.

Another area in which there has been great interest in the past ten years is outpatient surgery in gynecology. Tubal ligation, Bartholin's gland marsupialization, diagnostic laparoscopy, dilatation and curettage, pregnancy terminations, conization and uterine manipulations have been performed on an ambulatory basis. This arrangement however, requires immediate access to an operating suite and gynecologic surgeons competent to handle complications which may arise. The advantages of this modality is that it is cost effective since the patient does not have to undergo hospitalization. Although major insurance carriers have been slow to advocate this approach, it is one which will probably be used with increasing frequency in the future.

Potential Detriments

Having described the value of technologic advances in ambulatory obstetrics and gynecology, one needs to assess the potential detriments of such techniques. The principal problem with new technologies are that they may foster over-confidence and over-reliance on the information derived and cause deterioration or non-use of basic clinical skills (see Figure 1). For example, the NST/CST is extremely useful in detecting fetal compromise, but it should not replace historic and physical assessment during the antepartal period. Similarly, it is important that providers not pay more attention to the results from new technologic advances than they do to the patient. The very fact that we consider our patients as persons and demonstrate compassion is critically important to their recovery and well-being. Thus, in many areas it is stated that the reliance on technology has allowed providers to develop apathy about the patients' personal feelings (see Figure 1). This phenomenon certainly cannot be critically measured but is one of the chief dangers of new technology.

Another problem is the expense of newly de-

veloped technology. Since many of the machines such as the colposcope, fetal monitors, laser and the ultrasound are expensive, both in initial outlay and in personnel cost, it is tempting to utilize these modalities in every patient. This allows for financial remuneration but obviously most of these techniques are not needed in every subject. Certainly, perinatal risk assessment by history, physical and laboratory assessment is one of the areas in which every patient would seem to benefit. In contrast real-time ultrasonography, non-stress testing, or colposcopy are areas in which selective use of technologic advances is recommended. Although some providers tend to justify these tests in each patient on medicolegal grounds, the use of clinical skills to assess which patients need these various methodologies appears more reasonable. Also, the impact of some of the methods on the patient or fetus of pregnancy is unknown. Ultrasound, fetal monitoring, laser therapy and cryosurgery have all been mentioned as modalities which might lead to damage of the mother/fetus/neonate if the procedures are used indiscriminately. For all these reasons, technical procedures are best selected for use on a clinical basis.

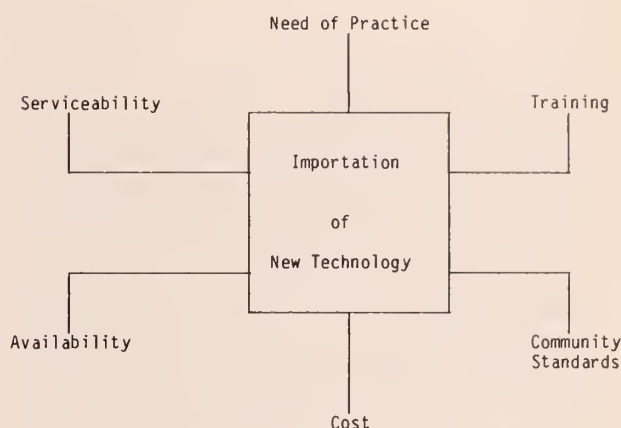
Another important area is the impact of the new technology on the office setting (see Figure 2). Some of the basic questions to be asked are related to one's own practice. For example, there is no need to import expensive equipment if in the local ambulatory unit of the hospital or surgi-center it is readily available and acceptable. In addition, if a practice consists of primarily gynecology it would not be cost effective to purchase a fetal monitor for NST and OCT's. The estimated volume of patients who would need the specific tests should be calculated to assess its cost-effectiveness. Obviously the charge of such a technology is passed on to the patient and one must make certain that the patients, third party insurance, and governmental agencies will be willing to subsidize such a cost.

The issue of training should also be addressed (see Figure 2). The question should be asked: "What is sufficient experience with this modality and if not currently available how can it be attained?" For an example, in most settings providers can obtain didactic education to give them experience with new modalities such as ultrasound, fetal monitoring, colposcopy, etc. It must be emphasized here, however, that a three day or week-long course as the only prelude to importing new and expensive technology would not appear to be appropriate. After one assesses that a new technology is needed and will be cost-effective in the practice, it is obviously important that one be trained extensively in this area.

FIGURE I

<i>Advantages</i>		<i>Disadvantages</i>
Cost-effective	New technology advances	Cost
Information		Depersonalization
High standards		Invasive
Avoid malpractice		Erode clinical skills

FIGURE II



Finally, the issue of training for office personnel should be assessed. In most cases, it is acceptable to train a technician or office nurse to perform the ultrasound, the NST's, etc., thus freeing the physician from the mechanical portion of the test and let him/her be involved in its interpretation. This step obviously must come after the physician is thoroughly familiar with the specific technology and is well versed in the complications and technical problems which may arise. Other more practical problems with new technology involve its serviceability and how it will fit into the practice of a community as a whole. Serviceability is one of the key issues, since most new technology is expensive and the desired results cannot be obtained if the modality is not working properly. Therefore, a service agreement at least for the first year from the supplier of each new modality is recommended. This, as well as the time required for service and the use of "loaner equipment," should be investigated. In many cases major suppliers will allow the practice to borrow these machines prior to purchase, and in this way one can assess the usefulness of the modality as well as the problems which might be incurred.

Summary

In summary, recommendations regarding new technology involve three questions (see Table 1).

TABLE I
RECOMMENDATIONS

-
- Need for New Technology
 - Practice
 - Patient
 - Provider
 - Education
 - Provider
 - Consumer
 - Cost Benefit Ratio
-

First, is the new modality worthwhile for you and your patients? One must make certain that the technology is needed within the specific practice area and that the patients who will be bearing the cost of this technology will gain sufficient benefit.

Secondly, there is a question of education and training. It appears important that the person or persons using the machine be extremely familiar with what it can and cannot offer as well as the various problems associated with the method prior to using the data or methodology for patient care decisions. It is most helpful for a specific member of a group to be trained in each of the new technology areas rather than one person trying to master all the technologic advances in ambulatory obstetrics and gynecology. This will also assist the provider in avoiding the medical malpractice problems that may arise from the use or non-use of technologic advances. It should be emphasized that the standard of practice in the community is important in determining if and when to import a new technology to your area.

Finally, there is the question of how this will be received by the patient. One should be certain that the information you would receive from a new procedure is worth not only the cost but also the impact upon patient care in one's practice. Many patients

perceive this wave of new technology as making the physician less accessible rather than closer to the patient. Many of our patient care decisions are based upon information obtained from these new technologic advances, but this should not make us more remote from the patients. In many cases it should further stimulate the use of our clinical skills, thus adding to, rather than subtracting from, the information gained from the new modalities. For this reason, it is suggested that new modalities should be additive or supplemental to clinical skills and personal interaction with patients rather than the opposite. Critical evaluation of the technologic advances and their impact should be undertaken before importing them into the ambulatory setting. ★★★

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Sick — A Way Of Life

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IN OUR MODERN industrial society you will be labeled a "bum" unless you produce — only the sick, rich and criminal are exempt. Many who cannot tolerate the stress of being productive become sick. Society tolerates, rewards, and even encourages those who refuse to work to accept the sick role. The fear that if we allow one to loaf "all will loaf" is so great that we are willing to pay people to stay sick. Work, power and illness are the only major roles which we openly permit. Man, the machine, must produce when not in repair.

We physicians, with our great need to heal, find it very difficult to work with patients who cannot be healed. We seem unable to realize that some patients need their illness just as much as we need our work. We work best with those patients whom we can diagnose, treat and relieve. We readily accept that stress causes many illnesses, but seldom do we realize that illness can be a stress-relieving mechanism.

Hans Selye pointed out several years ago that stress is an important factor in any illness.¹ It may be that stress interferes with the immunological mechanisms, so as to make us more susceptible to disease.

McClellan has noted that salivary IgA levels are lower in people with Type A personalities. This could be a factor which makes certain people more susceptible to some diseases. He suggested that love and relaxation might increase IgA levels so as to give us an increased immunity against illness.²

The relationship between stress and illness is well documented in medical literature. On the basis of the stress-illness data, I have come to believe that even the common cold, which we are more likely to become victims of during times of stress and reduced immunity, is often an indication that we need to escape from the demands of society for a short while. Rest and isolation allows our immunological and psychological defenses to readjust so that we are once again able to cope with the pressures of life.

The author discusses the need for and value of regularly scheduled appointments for those chronically ill patients who have often adopted sickness as a way of life. These patients include those with headaches, backaches, peptic ulcer disease, depression, anxiety, various psychoses, etc. The author presents a case involving an alexithymic woman with chronic headaches. He makes reference to a recent survey of the older physicians in the community and points out the great value they place upon a good doctor-patient relationship.

In this article I am writing most specifically about those chronically ill patients who suffer with headaches, backaches, peptic ulcer disease, depression, anxiety, various psychoses, etc. These are the patients who often adopt sickness as a way of life.

When I sometimes try to tell my colleagues that some patients need their illness, I am often ignored. I have learned to accept such rejection because the physician's need to cure is greater than his need to understand. Many times all the chronically ill patient needs to know is that his illness is not more serious or fatal.

Case Report

A 49-year-old married white female patient has complained of intermittent headaches, lasting one to three days, since adolescence. For years she treated herself with aspirin and a few days of bed rest. Her mother and other female members of the family also had similar headaches. In this family women were expected to have headaches. They called the illness "migraine." I suspect that many of the headaches were migraine, but most could be classified as tension headaches. This patient's headaches had not subsided nor diminished with menopause, and she had not had a typical migraine headache in years.

Dr. Runnels is in the private practice of psychiatry in Hattiesburg, MS.

She started seeing her physician for treatment of headaches after she married a man who could not tolerate sickness. He wanted her cured. After seeking medical help, she was treated with numerous analgesics, tranquilizers, and antidepressants with no change in the source or severity of her symptoms. Occasionally she was given intramuscular injections, including narcotics, but she showed no signs of addiction.

The headaches were often preceded by stressful situations. An argument with her husband, children or relatives was sure to lead to a severe headache and a midnight trip to the emergency room for an injection. After the injection she would sleep for several hours and awake free of pain.

She saw her physician at infrequent intervals for various medical problems and for headaches. She was no particular problem for the physician. However, he became concerned about having to give her habit-forming substances. On her last visit he told her that he could no longer prescribe narcotics for her, and that she needed to see a nerve doctor, a psychiatrist. She complied with his request, but with fear that he had either found something seriously wrong or he no longer wanted her as a patient. She even wondered if he thought she was an addict.

She came to see me even though she was not looking for psychotherapy. She was not dissatisfied with her life and she saw no need for change. She said, "I can live with the headaches if I know that there is not something bad wrong."

This woman will continue to need to see her physician at intervals for reassurance and for treatment of other illnesses. Such patients develop pneumonia, cancer, and other illnesses just as the rest of us do. We must be sure to give these patients the same expert medical attention which we give all our other patients. We must not be so blinded by an emotional label that we fail to look for the usual illnesses in our chronic patients.

Koranyi found somatic illness in 9%-42% of the psychiatric patients which he studied.³

Several years ago I found that 50% of the patients in our 20 bed psychiatric unit in a general hospital had some physical illness which required treatment during their hospital stay.

This patient will continue to have headaches at times of stress, and sometimes she will require more than aspirin to get her through the crisis. She will not likely become addicted unless her physician insists upon curing her or supplying her with addicting substances, so that he will not be disturbed at night when she needs help. If someone does succeed in curing this woman's headaches, she will need to

develop another illness, possibly a more incapacitating one, to serve as a stress-relieving mechanism.

This patient talked for 45 minutes about her many very real problems, but she did not feel that coming to see me would do anything except increase the family's already heavy financial burden. She was oriented to changing the world and not herself. In light of her inability to feel her own emotions and to resolve her conflicts through fantasy, she is not likely to benefit from insight psychotherapy. With the aid of biofeedback and other mechanical interventions, she may be trained to become more aware of her muscular tensions so that she may develop ways other than illness to relieve stress.

Discussion

Most patients with chronic headaches and other psychophysiological illnesses can only talk about their body symptoms and external problems. Stress as a cause for illness is so strange to these people that they think you are accusing them of imagining their symptoms when you fail to find a physical cause for their symptoms. Many of these patients are alexithymic.

According to Nemiah, "alexithymia is a psychological set of characteristics commonly seen in patients with psychosomatic disorders. It is marked by two main features: (1) significant difficulty in expressing feelings in words, and (2) lack of fantasies appropriate to or expressive of feelings, the thought content of the patient being dominated by details of events in the external environment."⁴ Such individuals cannot feel or accept normal emotions. They cannot be just sad, bad, glad, or mad. What they feel when under stress is pain and body dysfunctions. You would think that those who experience emotions through illness would be in touch with their bodies, but through some unexplained emotional malfunction they only experience their body when it performs poorly.

The chronic patient who keeps coming in with new and different complaints is often the one who has not yet been able to develop an acceptable illness — one which relieves stress and is acceptable to the patient, the family, the community, and the physician. These patients need an illness which is not too threatening, but yet is severe enough to require attention.

Most chronically ill patients do better if they have regularly scheduled appointments with their physicians. The appointments should be at least weekly during crisis, and every one to three months when the patient is stable. The important factor is that the patient should have a definite time to return to see the

physician. If the appointments are not too far apart, the patients will manage their own problems between visits to their physician.

Nemiah, when recommending treatment for the alexithymic individual, said, "Given the current state of our knowledge, for most patients the lasting supportive relationship with his physician in conjunction with the indicated physical and pharmacologic measures of treatment, appears to be the most useful and effective therapeutic regimen that is currently available."⁵

Baskin, in recommending treatment for migraine headaches, said, "A supportive physician-patient relationship permitting emotional contact, dependency-need gratification, and reassurance probably has greater impact in modification of the anxiety that may both trigger and arise from migrainous attacks."⁶

McCawley, when writing about management of psychosomatic abdominal pain, said, "Detail exploration of the psychological problems of the patient, either by the primary physician or by the psychiatrist, more often than not fails to produce any improvement to match increased understanding. In fact, if understanding is pushed too quickly, the patient may even get worse. Therefore, any attempt to understand and express emotional difficulties has to be accomplished by an attempt to 'unlearn' or at least modify the conditioned behavior."⁷

The regularly scheduled appointment often avoids the patient's having to get sick to justify contacting his physician. Scheduled appointments help to reassure the patient that he is not developing a more severe illness. They reduce the number of unnecessary phone calls. They strengthen and maintain a good doctor-patient relationship, which is the doctor's best insurance against a dissatisfied patient and nuisance lawsuits. The regularly scheduled appointment is a great stress-relieving mechanism for the chronically ill patient.

I am sure that the most help I give my chronic patients results from seeing them at regular intervals, listening to their complaints and respecting their right to be sick or well.

Lack of motivation is a common problem among the chronically ill. Nir and Cutter wrote in 1978, "The lack of motivation does not necessarily reflect intrapsychic conflicts, but may be related to a cognitive style or a cultural bias, confounding factors and forces within society that have a vested interest in maintaining the status quo on the basis of economic and ethnic considerations. . . . Addressing the common denominator, lack of motivation, might result in the development of more efficient and effective

interventions."⁸

It behooves us not to accept chronicity in the early phases of a patient's illness; but once chronicity is established we should refocus our efforts and care for the chronic patient in a supportive way.

In spiritual circles we hear of dramatic, sudden healing of the chronically ill. Our first impression, if we can shed our doubts, is "what a blessing," but with a closer look we see another problem. The suddenly cured person often is faced with no way of providing for himself. His occupation — being sick — is swept away from him with one blow. Now, family, friends, and society all expect him to be productive — something he has forgotten how to do, if he ever knew. A close analogy in our modern society is that of taking from a disabled individual his social security benefits.

A large part of my psychiatric practice is made up of chronically mentally ill patients. They are not involved in insight psychotherapy. For many of my patients my only goal is to keep them well enough so that they do not have to be hospitalized for any long periods of time. These patients are seen on a regularly scheduled basis ranging from weekly to twice a year. Appointments range in time from 15 minutes to one hour, with most appointments being for 30 minutes. The therapy time is spent evaluating real problems, medication regulations, and brief medical observations.

A recent random survey of my appointment book revealed that 50-60% of my patients are chronically ill. They will need to see me or some other therapist at frequent intervals for the remainder of their lives. Some 20-30% of my patients can be expected to recover or gain a good remission in a period of time. The remainder of the patients were seen for consultations with other physicians or for short term therapy, usually only two or three visits. This large number of chronic patients is an accumulation from practicing in the same area for several years. It is only by seeing my chronic patients on a scheduled basis for shorter periods of time that I have any time for treating patients who have a better prognosis.

Summary

Recently I interviewed several of the older physicians in our community, those who had practiced medicine for over 30 years. They were all proud to be physicians, and their greatest rewards had come from their long years of patient care. They had learned the value of seeing patients on a regular basis, sometimes for years. They had learned to always physically examine their patients, each visit, even if only very briefly. They knew the value of

sitting down with their patient, if only for a few minutes. Their experiences supported my opinion that a few unhurried minutes spent listening to and examining patients greatly enhances the patient's assurance that they have had the very best their doctor has to offer.

The specialized physicians will continue to practice medicine with their tools and human specimens, but most of us could do far better in assuming our responsibility for our chronic patients by becoming their primary physician and seeing them on a regularly scheduled basis. Scheduled appointments aid the chronically ill patient in accepting their physician as a member of their extended family with increased trust and respect. Patients' trust and appreciation are the greatest rewards which the practice of medicine has to offer the physician.

Kudrow said in his article on managing migraine headaches, "For the physician a major benefit of periodic revisits is greater insight into his patient's disorder, and for the patient there is establishment of a bond of trust and confidence between herself and a

supportive physician."

To learn to take care of the chronically ill patient is to learn that many times we need to comfort more than we need to cure. ★★★

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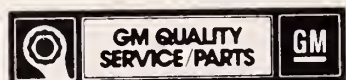
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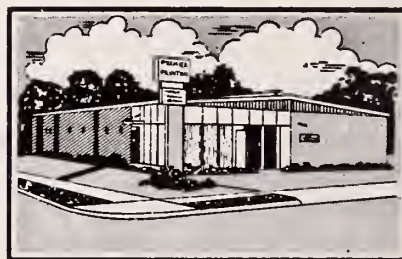
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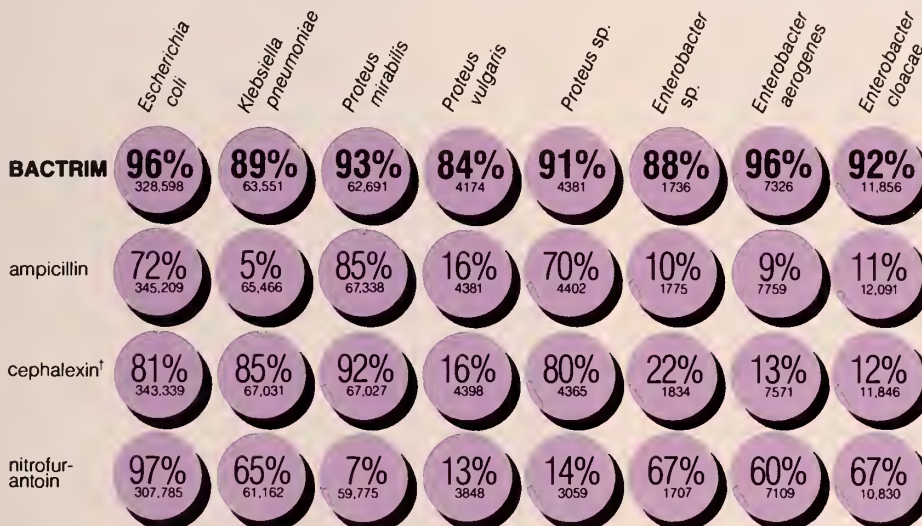
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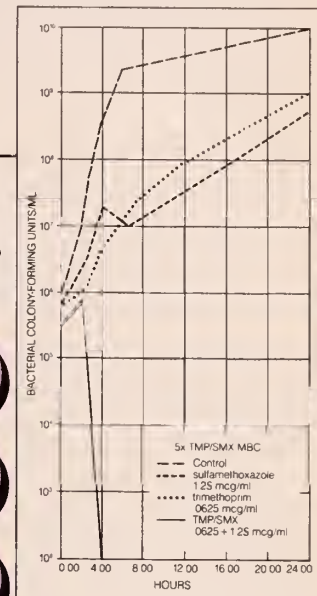
Percent of isolates of common uropathogens sensitive to BACTRIM and to other antimicrobials



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b.i.d. for recurrent urinary tract infections

^{*}*In vitro* data do not necessarily predict clinical results.

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Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent. For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombocytopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients. **Pregnancy:** Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folate metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, alaxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, perianteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goutogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of gout production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. **Tablets,** each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100. **Prescription Paks of 40. Pediatric Suspension,** containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). **Suspension,** containing 40 mg trimethoprim and 200 mg sulfamethoxazole per tea spoonful (5 ml); fruit-licence flavored—bottles of 16 oz (1 pint).

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BRIEF SUMMARY PROCARDIA® (nifedipine) CAPSULES

For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g. where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy, Category C: Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse effects include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2%, and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse effects were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77° F (15° to 25° C) in the manufacturer's original container.

More detailed professional information available on request.

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*"My doctor switched me to
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available. The change in my condition
is remarkable."*

*"I shop, cook and can plant
flowers again."*

*"I have been able to do volunteer
work...and feel needed and useful
once again."*

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,¹ taking fewer nitroglycerin tablets,² doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



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- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA brief summary on adjoining page

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Radiologic Seminar CCXXXIII: Visualization of Meckel's Diverticulum by Radionuclide Imaging

BHARTI R. PATEL, M.D., CYRIL A. D'CRUZ, M.D., and JANE A. SANDERS, M.D.
Jackson, Mississippi

THE PREOPERATIVE diagnosis of Meckel's diverticulum was made by ^{99m}Tc -pertechnetate imaging in a seven-month-old patient presenting with painless rectal bleeding. Gastrointestinal hemorrhage associated with Meckel's diverticulum is secondary to peptic ulceration of the intestinal mucosa adjacent to the aberrant gastric mucosa in the diverticulum. The isotopic study is predicated on the affinity of ^{99m}Tc -pertechnetate for parietal cells of gastric mucosa. Excellent correlation with pathological examination of the specimen was obtained.

Case Report

A seven-month-old black male was brought to the pediatric emergency room with a complaint of bright red rectal bleeding of acute onset. The past medical history was unremarkable and the physical examination was normal except for grossly bloody stool in the rectal vault. The etiology of the bleeding was felt most likely to be either colitis or Meckel's diverticulum. The Meckel's scan done on the day of admission demonstrated a focal area of activity in the right lower abdominal quadrant within ten minutes after injection which became more pronounced with time (see Figure 1), along with stomach mucosal activity. The patient had a second episode of bleeding per rectum to the extent that transfusion with two units of blood was required. Surgical exploration was performed the day following admission, and a Meckel's diverticulum was found in the mid-small bowel area.

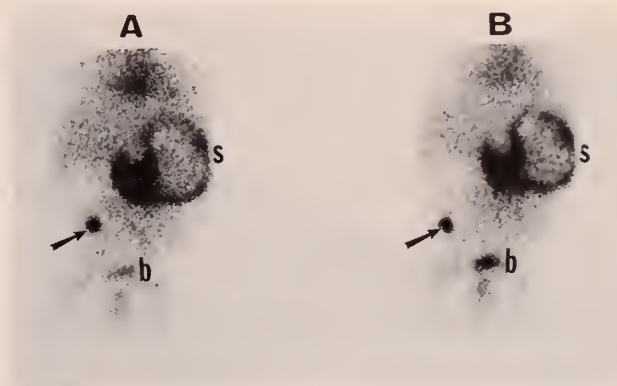


Figure 1. Abdominal scan showing focal area of activity (arrow) in lower right quadrant at 10 minutes (A) and at 20 minutes (B); s = stomach, b = bladder.

Examination of the excised specimen demonstrated typical acid secreting gastric mucosa lining the tip and distal one-half of the diverticulum (see Figure 2). A small focus of pancreatic tissue was also noted. The adjacent intestinal mucosa of the proximal segment revealed a small ulcer (see Figure 3), which was probably the source of the hemorrhage.

Discussion

Meckel's diverticulum occurs in 1.5%-3% of the general population, with a male to female ratio of 3:1.¹ Embryologically it represents the persistence of the proximal segment of the omphalomesenteric duct. This duct is present in early embryonic life and normally becomes atrophic and disappears by seven weeks of gestation. The remnant manifests itself as an outpouching from the antimesenteric border of

Sponsored by the Mississippi Radiological Society.
From the Departments of Radiology (Drs. Patel and Sanders)
and the Department of Pathology (Dr. D'Cruz), University
Medical Center, Jackson, MS.



Figure 2. Gastric mucosa in distal half of diverticulum. Hematoxylin and eosin $\times 200$ original magnification.



Figure 3. Ulcer (arrow) in proximal half of diverticulum lined by intestinal mucosa. Hematoxylin and eosin $\times 40$ original magnification.

the bowel. The diverticulum contains primitive endoderm capable of differentiation into any component of the digestive tract. Consequently about 50% of diverticula do contain heterotopic tissue with gastric mucosa being the most common. Occasionally pancreatic tissue (as in this case), jejunal or colonic mucosa may be seen. Although it may be found anywhere along the gastrointestinal tract from the stomach to the rectum, the most common location is the ileum, 20-40 cm from the ileocecal valve. It usually measures 3-5 cm in length.

When symptomatic, Meckel's diverticulum usually presents in the pediatric age group with painless rectal bleeding as the most common manifesta-

tion. Other rarer modes of presentation include intestinal obstruction, intussusception, inflammation or perforation.

Since Meckel's diverticulum is a common cause of gastrointestinal bleeding in the pediatric age group, ^{99m}Tc -pertechnetate abdominal scanning has proven to be a very useful non-invasive tool in evaluation of the cause of the gastrointestinal bleeding in pediatric patients. Preoperative diagnosis of Meckel's diverticulum as the cause of gastrointestinal tract bleeding is otherwise difficult. Because of the lack of standard radiographic techniques, diagnosis of Meckel's diverticulum is rarely made by barium study.¹⁻³ Mequid and his associates reviewed 32 infants under two years of age who had undergone surgery for painless rectal bleeding due to Meckel's diverticulum. In the study, 91% of the infants had barium enema and 44% had upper gastrointestinal examination. In none of these examinations was the cause of painless bleeding per rectum identified. They feel that the use of barium by mouth or by rectum is unwarranted because of rare visualization of barium entering the diverticulum.⁴

Preoperative diagnosis of Meckel's diverticulum utilizing ^{99m}Tc -pertechnetate has been utilized in adult patients also.^{1, 2} Because of its noninvasive nature and ease of performance in a short time, it should be utilized in evaluation of gastrointestinal bleeding in adult patients with appropriate clinical indications. In the past, the use of a nasogastric tube has been advocated to deflate the stomach³ but this was thought to be unnecessary by Dr. Ho and her colleague, who felt that intubation caused discomfort to the patient.⁵ We did not utilize any stomach deflation measures. Pre-medication with potassium perchlorate to depress thyroid uptake has also been suggested³ but was not utilized in order to allow maximum uptake in the gastric mucosa of the Meckel's diverticulum. A finding of Meckel's diverticulum with gastric mucosa was seen on a satisfactory study and was confirmed by pathological examination.

The positive radionuclide scan findings in Meckel's diverticulum are due to the presence of functioning gastric mucosa. ^{99m}Tc -pertechnetate is concentrated most probably by the acid secreting gastric mucosa. The parameters of this technique are specificity 79%, sensitivity 75%, and accuracy 78%.⁶ Uptake in the gastric mucosa of a Meckel's diverticulum with both acute and chronic small intestinal obstruction has also been reported.⁷ Urinary activity in the renal outflow tract, abdominal aneurysm, hemangioma and peptic ulceration resulting in the accumulation of activity in the lower abdominal re-

gion may be responsible for false positive studies.

★★★

2500 North State Street (39216)

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Home Health Services — Prescription for Continuing Care

JOE HAGGERTY, M.P.H. and EUGENE MURPHEY, M.D.

Tupelo, Mississippi

HOME HEALTH CARE, as an alternative to long-term institutional care, has become a valuable resource in many communities. It provides needed services to a variety of people, especially those elderly ill who are functionally impaired. Although many of these persons receive needed emotional and physical support from relatives and friends, the professional assistance for health problem treatments and health care therapy is an important ingredient that often prevents hospitalization.

Home health services have been defined in many ways, but the most complete definition has been derived from the combined efforts of the various national organizations involved in promoting home health care services.

Their definition says: "Home health service is that component of comprehensive health care whereby services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability. Services appropriate to the needs of the individual patient and family are planned, coordinated and made available by an agency or institution, organized for the delivery of health care through the use of employed staff, contractual arrangements, or a combination of administrative patterns. These services are provided on an intermittent basis under a plan of care established by the patient's physician. The plan of care includes appropriate service components such as, but not limited to, medical care, skilled nursing, physical therapy, speech therapy, respiratory therapy, occupational therapy, medical social services, nutrition, homemaker, home health aide, laboratory services, durable medical equipment, and supplies."¹

November 27-December 3 is National Home Health Services Week. In this report the authors describe home health care as a field which is beginning to receive increasing recognition as a viable, cost-effective alternative to institutionalization. They state that hospital-based services in particular represent a valuable means of maintaining both the continuity of patient care and the quality of services provided to home-bound patients. They describe the type of patients who are potential recipients, the various services available, and the present views and future outlook of these services.

A chronic condition such as arthritis or diabetes can cause functional impairment, but is usually not enough to indicate the need for long-term institutional care. The degree of functional impairment is determined by the elderly person's ability to handle daily activities and moving about without assistance. Elderly who are functionally disabled are often bedridden, need assistance with dressing and bathing, or need help in moving around outside the home. These people are typical candidates for home health care and do not necessarily require institutionalization. Availability or lack of institutional facilities, willingness of family or friends to care for the person, costs of care, the person's reluctance to enter an institution, and availability of home care all are important variables to consider when deciding whether a person should enter an institutional facility. Home health care provides a viable alternative for those elderly for whom institutionalization is not the answer.²

From the North Mississippi Medical Center, Tupelo, MS.

HOME HEALTH SERVICES / Continued

Home health services are furnished by a diverse group of providers. These providers may be grouped into the following general categories: governmental (ie, public health department), hospital-based, private non-profit, voluntary, and proprietary (for profit). These categories reflect the financial status of the agency rather than the scope of services available because most agencies provide a menu of the services mentioned previously.

Hospital-Based Program

Home health care and hospitals have had an extended relationship although the visibility of these services has at times been tenuous. One of the earliest instances of this relationship was a plan developed in 1796, when the Boston Dispensary sent physicians-in-training and nurses into the homes of the sick poor.³ While the practice of sending physicians into the home almost disappeared in the intervening years, today it is once again being stressed.

Hospitals re-entered the home care field in the 1940's when the shift in hospital populations from those with acute communicable diseases to those with more chronic or complicated illnesses, overcrowding, and the increasing cost of inpatient care led to explorations of other means to provide care. In the 1960's efforts increased to provide post-hospital care through a multidisciplinary, coordinated program of care in the home. Since Medicare was enacted in 1966, there has been a 70% increase in hospital-based programs.

Advantages

Hospital-based programs provide a number of advantages to physicians and their patients. First, "continuity of care" is enhanced because of the smooth transition from inpatient to home care. Second, the hospital-based program may draw from a vast resource of expertise from within the institution and then deliver this to the homebound patient. Third, hospital-based programs are equipped to keep costs down through various methods such as sharing billing services with the parent agency and buying supplies through shared purchase agreements with other hospitals. Finally, physicians can maintain involvement with a hospital-based program through involvement with the hospital medical staff, thereby assuring quality and appropriateness of the services provided.

Persons concerned about the appropriate use of home health services frequently hear such state-

ments as, "Physicians don't utilize home health services very often"; "They are unaware of the benefits available in the home"; and "Physicians worry about the quality of service delivered in the home." To determine how real or imaginary these observations were, the Alliance for Home Health Services in St. Louis, Missouri, authorized a survey of the St. Louis physicians. A questionnaire was mailed to 1,590 practicing physicians in St. Louis City and St. Louis County. All together, 476 usable questionnaires were returned. The reasons for referring patients to home health agencies were ranked by physicians who used these services. Of the physicians responding, the three most frequent reasons listed were: (1) home health services provided assistance to family members in caring for patients, (2) home health services provided an alternative to hospitalization or institutionalization (ie nursing home care) and (3) home health services were viewed as being less costly than other alternatives.

Current Attitudes

Not surprisingly, the responses tended to support the rationale given by respondents as to why they use home health services. Of the 323 who replied to a question concerning the positive aspects of home health services, 81 physicians (25%) stated that the patient's home provides more comfortable surroundings for (long-term) care of patients. A second reason pointed to the possibility for continuity of care by following hospital or office-based care with home health care (20%). A third leading reason noted that home health care was often a more appropriate level of service than hospital care (13%).

Several specific quotations made by physicians express graphically the above reasons: "Home health care — a superb transition from the hospital environment and dependence, to independency with a bridge of security . . . home health care — a great help to the overall care of the patient, especially the geriatric group."

In total, nearly two-thirds (63.5%) of physicians responding were "very satisfied," one-third (34.4%) were "somewhat satisfied," and only (2%) were dissatisfied with home health services.⁴

Future Outlook

The future of home health services seems bright. Beginning in October 1983, hospitals which are Medicare certified will begin to receive reimbursement under a new payment system. This system is entitled the Medicare Prospective Payment System

by Diagnosis Related Groups (DRGs). Under this system hospitals will be paid a flat rate specific for each diagnosis. A predetermined number of days for hospitalization are included in this rate; therefore, the hospital will be encouraged to seek home health services as an alternative to extended institutionalization.

Another area of growth can be found in hospice services. Hospice is a program of services, similar to home health, which emphasizes palliative care for patients with a terminal illness. Medicare has created a new benefit which will pay for hospice beginning in November 1983. Finally, the growth in the population of the elderly, due in part to improvements in health care, will challenge the entire spec-

trum of providers to diversify or expand their services to meet the special needs of these consumers.

★★★

830 South Gloster Street (38801)

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NOTICE

Mississippi Disability Determination Services has need of physicians to serve as consultants to medical examiners. This is a part-time position. The basic requirements are: 1) an unencumbered license to practice medicine in Mississippi and 2) facility in the English language. Those interested should call Mrs. Deborah Warriner, Medical Staff Coordinator. WATS-1-800-962-2230, Extension 2153; Jackson, 922-6811, Ext. 2153.

Physicians interested in doing consultative evaluations (according to Social Security guidelines) should contact either Ms. Catherine Hughes (Ext. 2275) or Mr. Henry Klar (Ext. 2276).

The DDS now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should contact John S. Barr, M.D., Ext. 2277.



The President Speaking

A Different Form of "A.I.D.S."

Whitman B. Johnson, Jr., M.D.
Clarksdale, Mississippi

You only have to read the newspaper on any given day to see in what sorry state of health our nation finds itself. A chancery judge is charged with D.U.I. and speeding; outside inspection is necessary to oversee the safety of fair rides; 78% of the nation's hazardous waste dumps are not being adequately monitored because of the out of pocket cost; thirteen Chicago fans sue the White Sox to revise seating because they are unhappy with their playoff tickets; a lawyer faces charges of embezzlement and capital murder; a sheriff is arrested in a narcotics deal; one sixteen year old kills another at his junior high school desk; an airline takes chapter eleven bankruptcy after losing \$240,000,000 in the past quarter and labor claims it was done only as a "union busting" tactic; the Pentagon is called down for multi-billion dollar waste and favoritism in buying defense materials; a judge cites a woman for contempt of court for exercising freedom of speech and being critical of his decision in a letter to the editor of a weekly newspaper; and a woman having an affair with a married man complains about his not being true to her. Well, if that doesn't cover all "Seven Deadly Sins," it gets most of them!

These are only the symptoms of the disease, so what is the diagnosis? This country is suffering from "A.I.D.S." It is a symbiotic infection with two causative factors. Like Meleney's ulcer, it indolently destroys everything in its path, and unless the proper treatment is instituted, can be fatal. The two components of "A.I.D.S." are the Abandonment of Individual Duty and Authority Is Dead Syndromes.

For the past generation, we have been so busy improving the lot of the "Not so Fortunate," protecting and pushing our children so their lives would be better than ours, ridiculing those in authority, giving away rights and privileges without responsibilities, and depending on government and the courts to fulfill our needs and desires, that we have forgotten how to take care of ourselves and are approaching the cliffs of disaster.

During this period of time Chrysler and New York have bailed out of financial ruin; malpractice premiums, suits, settlements and judgements have skyrocketed along with expectations of patients; farmers have progressed from accepting subsidies to being given a dole for not working or planting; if the weather is too hot or too cold, too wet or too dry, that area gets disaster funds; drug abuse is

(Continued on page 314)

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXIV, Number 11

NOVEMBER 1983

That Competitive Edge

How many have heard the advertisements on the radio and news that end with "Your family chiropractor cares about you"?

How many have seen the bumper stickers stating, "Ask your pharmacist"?

How many have seen signs sitting on TV sets in showrooms across the country saying, "Your family optometrist cares about your sight"?

It really irritates me to see the growing encroachment of non-medical practitioners on the field of medicine. This has always been a problem; but now with the possible coming increase in doctors we need to re-think our position. We have the knowledge, means, and ability to contain these intruders into our profession. The only thing we lack is direction and motivation.

As you have read, nurse practitioners in California can diagnose, write prescriptions, and treat without supervision. Now New York is trying this, and I am sure others will follow in their wake.

What with physician assistants, nurse midwives, clinical pharmacists, podiatrists (the list goes on and on), we need to slow or stop this some time.

Surely our own AMA catches the blame for much of this, but who is the AMA but us! Even with all that they do for us, we need individually to re-dedicate ourselves to medicine. We need to be that knowledgeable, helpful, understanding friend that patients want and love. How much better we can help our cause by being a good doctor, citizen, friend, and staunch advocate of our patients.

Do you participate in organized medicine? Are you interested in seeing the advances in medicine come to pass as they should? Are you involved not only in medicine but also in church, community, and other organizations? Is it not our responsibility (as being often more fortunate than our fellow man) to do our best to help our people not only medically but also spiritually and economically? In my small town and in my small way, I try. I have been alderman/

mayor-protem; each year I put on health programs at school; examine the varsity and junior high basketball and football teams; give talks or show movies on health subjects; and give a \$200.00 science award with plaque at graduation. This year (October 1983) I had Family Health Month, with poster contests and the "grandest" Health Fair of all, with some 20 booths such as American Cancer, Mental Health, free hearing tests, and free blood pressure checks, free diet drinks, and (with the emphasis now on "wellness") an "Everybody Walkathon."

For months now I have listened to hourly radio advertising by the new Emergency Centers near me and I realize three things:

(1) I do not want to have to advertise like that.

(2) I need to compete on the terrain and with the weapons I know best — the practice of good medicine. But more I need to

(3) Let the people know that we care for them lovingly and professionally.

What I am saying is that you can sell yourselves and at the same time sell medicine to people without having to hire an advertising agency. In a word, "Do you have that competitive edge?"

JOSEPH E. JOHNSTON, M.D.
Associate Editor

BOOK REVIEW

Current Pediatric Diagnosis and Treatment: Seventh Edition. Kempe, Silver and O'Brien; Los Altos: Lange Medical Publications, 1982. \$26.00.

This should be a "must" reading for every student, resident, or physician who is in primary care medicine or who deals with children in any way. It is perhaps the ideal medical reference, being comprehensive, not ponderous, concise without being su-

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perficial, and above all up-to-date, highly readable and an ideal source of quick reference.

The references to current medical literature at the end of each chapter are outstanding and provide the physician with an opportunity to study each subject in depth, if he so desires, without requiring extra time to locate current references. All the sections are excellent; but I found those on normal childhood, nutrition disorders, adolescence, developmental problems of childhood and psychosocial aspects of pediatric and psychiatric disorders especially unusual, both for their inclusion in such a volume and for their excellent content. Of course, the usual sections on fluid and electrolyte therapy, drug therapy and antibiotics are outstandingly written and very up-to-date.

This book should be within reach of every practicing physician and any other professional who needs an up-to-date, adequate reference in the field of pediatrics.

ROBERT T. CATES, M.D.
12 Professional Parkway
Ridgeland, MS 39157

The President Speaking

(Continued from page 312)

almost an acceptable, although deplorable fact with our young; even under the supposed discipline of the armed forces, amid the Viet Nam conflict, many of our young men left the country to avoid serving, while other citizens openly opposed national policy and even sided with the enemy without getting as much as a slap on the wrist; and it's been said that medicine could not survive without the government Medicare and Medicaid subsidies.

Have we all forgotten what made this country great? At commencement, when the diplomas were being awarded, my class was told, "with this diploma go all the rights, privileges, and responsibilities that accompany the medical degree."

We treat a serious infection with mega doses of antibiotics. Do you think that 234 million units of individual responsibility might save the patient before debridement or amputation become necessary? It is none too soon to begin therapy. ★★★

MEDICAL ORGANIZATION

Medical History Exhibit Will Open Next Year



Antique medical instruments, medicine bottles and saddlebags are typical artifacts which have been acquired as furnishings for the Agriculture and Forestry Museum's medical exhibit.

Saddlebags belonging to the late Dr. John W. Melvin of Camden will be among artifacts displayed at the Country Doctor's Office, now near completion at the Agriculture and Forestry Museum in Jackson.

Highlighting the exhibit will be the actual building (constructed in 1905) in which Dr. Melvin practiced. The building was moved from its site in Camden and relocated to the museum grounds this summer, and is currently being restored.

The MSMA has contributed funds for the historical medical exhibit, located in the museum's "living village" section, which depicts life in Mississippi's

small towns around 1920. The MSMA Board of Trustees authorized support of the project as part of the association's 125th anniversary celebration.

Much of the museum complex, including the main exhibit building and the restored farm, was completed at the time of the facility's official dedication in September. Most of the construction work on the village section has now been finished. Additional research and design work is underway, according to a museum spokesman, and the doctor's office should be completed next spring.

Pediatricians Plan Annual Meeting

The Mississippi Chapter of the American Academy of Pediatrics will hold its annual meeting Nov. 18-19 at the University of Mississippi Medical Center in Jackson.

Speakers include Dr. William A. Daniel, Jr., of Birmingham, chairman of District VII of the American Academy of Pediatricians; Dr. Floyd Denney, professor of pediatrics at the University of North Carolina; Bruce W. McKinnon of Hattiesburg, president of a medical office management company; Dr. Robert E. Merrill, professor of pediatrics at the Southern Illinois School of Medicine in Springfield; and Dr. James Jorensen, UMC associate professor of pediatrics (cardiology).

Dr. Denney will present the Claude L. Batson Memorial Lecture on Saturday morning. His topic is "The Future of Pediatrics."

Course coordinator is Dr. Robert Abney, III, UMC clinical instructor in pediatrics. Sponsors are the UMC School of Medicine Department of Pediatrics, the Mississippi Chapter of the American Academy of Pediatrics, and the UMC Division of Continuing Health Professional Education.

There is no fee for this seminar. The American Medical Association will award 5 credit hours in Category I of the Physician's Recognition Award, and continuing education credit is offered.

For further information, contact Continuing Education at the University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Call 987-4914.



Dr. Guy D. Campbell of Jackson, left, Mississippi Lung Association volunteer, recently met singer Andy Williams, right, 1983 national Christmas Seal chairman. Dr. Campbell serves on both state and local levels as a member of the MLA Board of Directors and as MLA's national representative director to the American Lung Association. The 1983 Christmas Seal campaign will be conducted in November and December in Mississippi and the nation for support of lung disease prevention and control programs. The Santa displayed is a replica of the 1983 Christmas Seal design.

Perinatal Postgraduate Course Is Next Month in Jackson

The fifth annual Mississippi perinatal postgraduate course sponsored by the University of Mississippi Medical Center is set for December 15-16 at the Holiday Inn Downtown in Jackson.

Guest speakers are Dr. John C. Hobbins, professor of obstetrics and gynecology and acting department chairman and professor of diagnostic radiology at Yale University School of Medicine, and Director of Obstetrics at the Yale-New Haven Medical Center; Dr. George A. Little, professor of clinical maternal and child health at Dartmouth Medical Center and chairman of the Department of Maternal and Child Health at Dartmouth-Hitchcock Medical Center; and Dr. Rosanne C. Perez, professor of nursing and chairman of the Department of Pediatrics, Family and Women's Health Nursing at the Indiana University School of Nursing Graduate

Program, and adjunct professor of pediatrics at the Indiana University School of Medicine.

Also, Dr. Ronald L. Poland, associate professor of pediatrics at Wayne State University and Director of Neonatal-Perinatal Medicine of Children's Hospital of Michigan, and associate in Neonatal-Perinatal Medicine at Zutzel Hospital of Detroit; and Dr. Frederick P. Zuspan, professor of obstetrics and gynecology and chairman of the department at the Ohio State University College of Medicine in Columbus, and Obstetrician-Gynecologist-in-Chief of University Hospitals and Clinics.

Faculty participating from UCM include Dr. Blair E. Batson, professor of pediatrics and chairman of the department; Dr. Owen B. Evans, associate professor of neurology and pediatrics and director of the Division of Pediatric Neurology; Dr. Richard C. Miller, professor of surgery (pediatrics), assistant professor of pediatrics (surgery), associate dean for clinical affairs, and medical director of University Hospital; Dr. John C. Morrison, professor of obstetrics and gynecology and director of the Division of Maternal-Fetal Medicine; Dr. Sue M. Palmer, assistant professor of obstetrics and gynecology; Dr. Philip G. Rhodes, associate professor of pediatrics and chief of the Division of Newborn Medicine; Dr. William E. Roberts, maternal-fetal medicine fellow in the Department of Obstetrics and Gynecology; and Dr. Winfred L. Wiser, professor of obstetrics and gynecology and chairman of the department.

Course coordinators are Dr. Morrison and Dr. Rhodes. Sponsors are the UMC School of Medicine Department of Obstetrics and Gynecology Division of Maternal-Fetal Medicine, the Department of Family Medicine, the School of Nursing and the Division of Continuing Health Professional Education.

Fee for the seminar is \$200. Credit of 11.75 hours will be awarded by the American Medical Association in Category I of the Physician's Recognition Award and by the American Academy of Family Physicians.

For further information, contact UCM Continuing Education, 2500 North State Street, Jackson, MS 39216. Call 987-4914.



Interstitial Lung Disease Is Boswell Lecture Topic

The annual Boswell Lecture of the Mississippi Lung Association and its professional society, the Mississippi Thoracic Society, will be held Dec. 13 at the University of Mississippi Medical Center in Jackson.

The Boswell Lecture, established in 1971, honors the late Dr. Henry Boswell, who served as the first superintendent of the Mississippi State Sanatorium. Appointed in 1917, Dr. Boswell played the key role in reducing the tuberculosis death rate in the state from more than 4,000 a year to less than 200 during his 40-year tenure.

Presenting this year's lecture is Dr. Jack D. Fulmer, associate professor of medicine at the University of Alabama in Birmingham. His topic is "Current Trends in Interstitial Lung Diseases." Dr. Fulmer is a graduate of the Medical University of South Carolina and took postgraduate training at Alabama and

at the University of California in San Francisco.

Dr. Fulmer has been a visiting professor at several universities, including Yale, Vanderbilt, LSU, and UMC. He has been a guest editor for a number of professional journals, and currently serves on the editorial board of the *American Review of Respiratory Diseases*, the *Journal of Applied Physiology*, and *Lung*. Among his professional affiliations are the American Thoracic Society, the American College of Chest Physicians, the American College of Physicians and Sigma Xi. He is a past president of the Alabama Thoracic Society.

The author of more than 50 scientific articles, Dr. Fulmer is board certified in internal medicine and pulmonary diseases.

Course coordinator is Dr. Joe Norman, UMC professor of medicine, Director of the Pulmonary Division, Christmas Seal Professor of Pulmonary Disease and associate professor of physiology-biophysics. Sponsors are the University of Mississippi Medical Center and the Mississippi Lung Association.

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UMC Announces Faculty Appointments

The University of Mississippi Medical Center has added nine to its medical and centerwide faculties.

Dr. Norman C. Nelson, Vice Chancellor for Health Affairs and School of Medicine dean, announced the appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

Seven were appointed in the School of Medicine. Dr. E. David Crawford was named associate professor of surgery (urology); Dr. Owen Beverly Evans, associate professor of pediatrics, director of the Division of Pediatric Neurology and associate professor of neurology; and Dr. H. William Mott, associate professor of surgery (orthopedics). Dr. Andrew Spencer Anfanger and Dr. Indira Kota Veerisetty were appointed instructors in medicine. Dr. Cheryl Smith Hardy was named instructor in medicine (research) and Dr. Stephen Robert Rapp was appointed an instructor in medicine (research) and in psychiatry and human behavior (psychology).

Centerwide appointments include Dr. Donna Kay Gates, instructor in pathology, and Dr. Richard Leroy Summers, instructor in physiology and biophysics.

Dr. Crawford earned the M.D. degree at the University of Cincinnati, where he also completed his undergraduate studies. He took postgraduate training at Good Samaritan Hospital in Cincinnati and was awarded a fellowship in urology at the University of California Medical Center. Prior to accepting the UMC appointment, Dr. Crawford held an associate professorship in urology at the University of New Mexico, where he was on staff for five years.

Dr. Evans has been assistant professor of pediatrics and neurology for the past three years at Vanderbilt University School of Medicine. He earned the M.D. degree and took postgraduate training there in pediatrics and neurology. He also served as a staff physician in the United States Navy for two years.

Prior to his UMC appointment, Dr. Mott was in private practice in Tucson, Arizona, for a year and in Jackson, Wyoming, for eight years. He received his undergraduate degree from the University of Utah and was awarded the M.D. from the School of Medicine there. Dr. Mott took postgraduate training in surgery at the University of Iowa Hospitals and in orthopedic surgery at the University of California at Davis. He received a fellowship from the University of Texas.

Dr. Anfanger, who received the B.A. from Oak-

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UMC FACULTY / Continued

land University, earned the M.D. degree from Mississippi Medical Center, where he took postgraduate training prior to his appointment. He was on staff in the UMC clinical laboratory and a research assistant at Mount Sinai Hospital in New York before entering medical school.

Prior to joining the UMC faculty, Dr. Veerisetty was a resident at Mississippi Medical Center. He received the B.Sc. degree from Andhra Christian College in India, and the M.B. and B.S. from Government Medical College, where he also took his internship.

Dr. Hardy earned the Ph.D. at Mississippi Medical Center in 1978. She has been a senior research associate in medicine and in microbiology there and served as chief technician of the clinical laboratory for two years. Dr. Hardy received the B.S. degree from the University of Southern Mississippi and the M.S. from Louisiana State University.

Dr. Rapp earned the Ph.D. from West Virginia University and received the B.A. and M.A. from Bradley University. He completed a residency in clinical psychology at Mississippi Medical Center prior to his appointment. Dr. Rapp was a U.S. Peace

Corps volunteer in Bahia, Brazil, for three years and assistant professor for two years at Pontificio Universidade Catolica, Campinas, Sao Paulo, Brazil.

Dr. Gates received the B.A. from Northeast Louisiana University and earned the M.D. at Louisiana State University School of Medicine. She has been a resident in pathology at University Medical Center since July, 1980.

Dr. Summers, who received the B.S. from the University of Southern Mississippi, earned the M.D. at University Medical Center. He completed his internship there and has been a postdoctoral fellow in physiology and biophysics since June, 1982.

NEW MEMBERS

GALVEZ, RODRIGO M., Jackson. Born La Quiaca, Argentina, Jan. 12, 1933; M.D., Universidad Nacional De Cordoba, Cordoba, Argentina, March 1961; interned Mt. St. Mary's Hospital, Niagara Falls, NY, one year; anatomic and clinical pathology residency, Millard Fillmore Hospitals, Buffalo, NY, 1964-68; psychiatry residency, University Medical Center, Jackson, MS, 1976-79; elected by Central Medical Society.

PALMER, HERMAN T., Baldwin. Born Booneville, MS, July 27, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1981; interned University Medical Center, Jackson, one year; elected by Northeast Mississippi Medical Society.

SMITH, SYDNEY ALLEN, Gulfport. Born Jackson, MS, Aug. 4, 1941; M.D., Washington University School of Medicine, St. Louis, MO, 1969; interned University of Kentucky, Lexington, one year; medicine residency, same, one year; neurology residency, same, 1971-74; elected by Coast Counties Medical Society.

DEATHS

CHANDLER, T. K., Tunica. Born West Point, MS, March 3, 1911; M.D., University of Tennessee College of Medicine, Memphis, 1934; interned one year; member of Clarksdale & Six Counties Medical Society; died Aug. 22, 1983, age 72.

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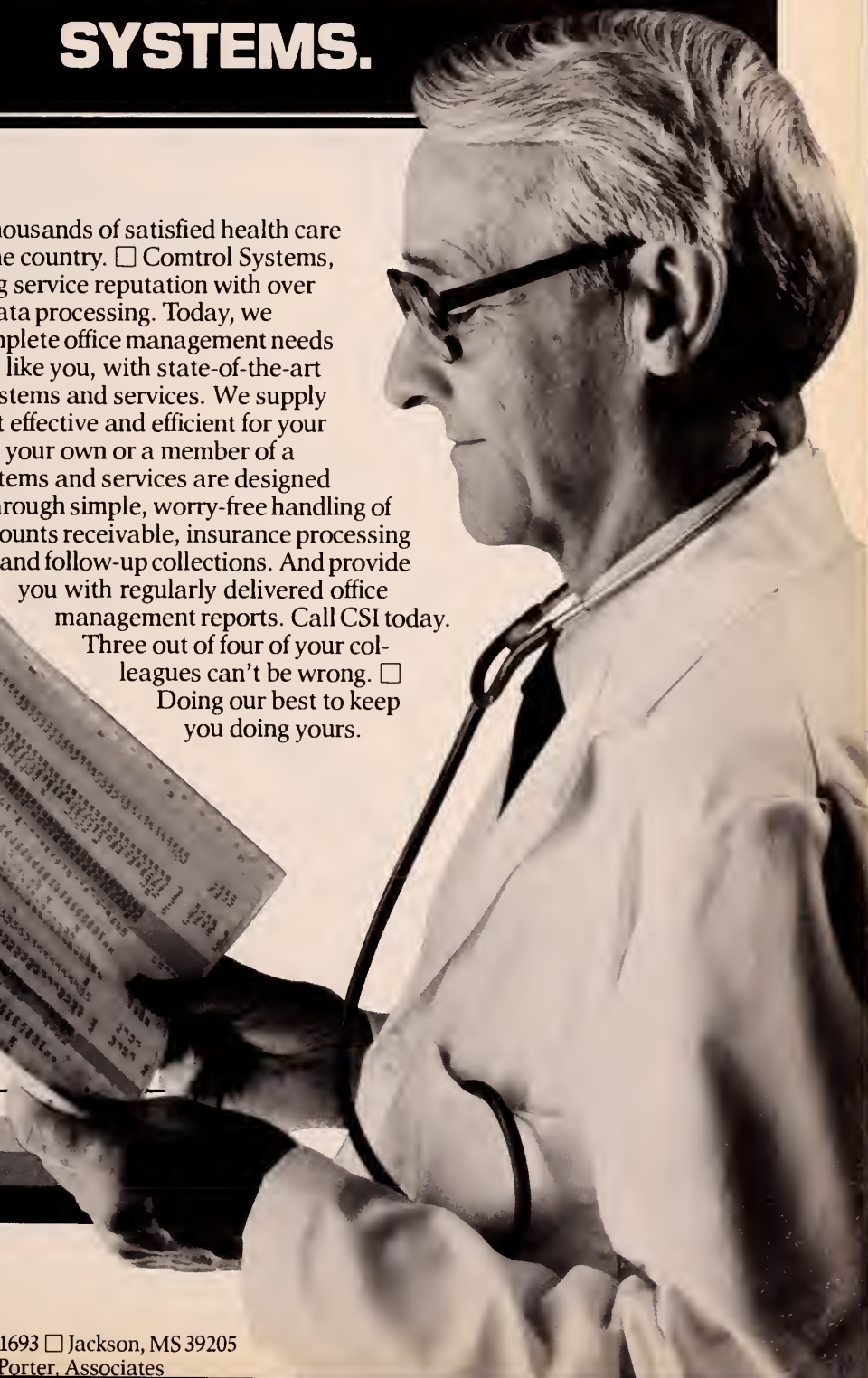
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PERSONALS

MARTHA J. BREWER has associated with MARY E. HAWKINS of Jackson for the practice of obstetrics and gynecology.

TERRELL BLANTON and RON CANNON of Brandon attended a recent course on laser surgery at the University of Virginia in Charlottesville.

CLAUDE EARL FOX of Jackson recently spoke during a symposium for the Governors' Association in Portland, Maine.

WILLIAM G. HARDIN has joined the staff of Rush Medical Group in Meridian for the practice of gastroenterology.

JAMES HARDY of UMC was elected president-elect of the International Society of Surgery at the recent meeting in Hamburg, Germany.

KAMAL ALY HASSAN announces the opening of his office for the practice of obstetrics and gynecology at 238 Kaki Street in Iuka.

BRIGGS HOPSON of Vicksburg spoke at a recent meeting of the Vicksburg Kiwanis Club and demonstrated Military Anti-Shock Trousers (MAST) to the group.

HERBERT LANGFORD of UMC presented a paper at the Council for High Blood Pressure Research in Cleveland, Ohio.

JAMES MAHER of UMC presented a paper at the 30th annual meeting of the International Society of Surgery in Hamburg, Germany.

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MSMA Auxiliary

EDWIN D. MEEKS, II announces the opening of his office for the practice of ear, nose and throat at 2102 Fifth Street North in Columbus.

T. F. McDONNELL of Hazlehurst was guest speaker at a recent meeting of the Central Chapter of the American Association of Medical Assistants, Mississippi Society.

RODNEY MEEKS of UMC was selected by the Mississippi Economic Council as one of 30 delegates in its Leadership Mississippi Program.

JOHN MORRISON of UMC was a panel member at a meeting of the Nurses Association of the American College of Obstetrics and Gynecologists in Chicago.

WILLIAM NICHOLAS of UMC spoke at a recent seminar sponsored by the American Diabetes Association at Keesler Air Force Base in Biloxi.

JAMES W. RAYNER of Oxford announces the association of JOSEPH SUPPLE for the practice of ophthalmology.

MICHEL RIVLIN of UMC lectured during a recent symposium on the aging female at Forrest General Hospital in Hattiesburg.

D. C. RUDEEN of Picayune announces the association of JAMES M. RISER for the practice of family medicine.

JOHN SHIELDS has associated with EDWARD PENNINGTON of Ackerman for the practice of obstetrics and gynecology.

GUY T. VISE, JR. of Jackson was installed as vice president of the Southern Medical Association at its annual scientific assembly in Baltimore earlier this month.

W. W. WALLEY of Waynesboro was featured speaker at a missions rally at South Side Baptist Church.

STEVAN A. WEBSTER announced the opening of his office for the practice of cardiology at Coastal Medical Center in Biloxi.

WINFRED WISER of UMC attended a recent meeting of the executive committee of the Society of Gynecologic Surgeons in Chicago.

HARVEY WRIGHT of Laurel was elected president of the newly-formed Hattiesburg-Laurel Ophthalmology Society. MILAM S. COTTEN of Hattiesburg is secretary-treasurer.

TRAVIS W. YATES and TIMOTHY H. LAMB announce the opening of their office for the practice of general internal medicine in Lyon.

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There are other important benefits with Valium as well—along with its broad clinical range, Valium has an efficacy/safety profile that few, if any, drugs can match. This record has been achieved with extensive clinical experience, undoubtedly including yours. And, as you must have observed, side effects more serious than drowsiness, fatigue or ataxia rarely occur. Nevertheless, as with any CNS-acting agent, patients should be cautioned about driving, operating hazardous machinery or ingesting alcohol or other CNS-depressant drugs while taking Valium.

Yet another benefit Valium affords is flexibility.






Available in 2-mg, 5-mg and 10-mg scored tablets, Valium enables you to titrate dosage to individual patient needs. For the geriatric patient, a starting dosage of 2 to 2½ mg once or twice a day is recommended. And, for patients who forget or skip medication, you can prescribe Valrelease™ (diazepam/Roche) 15-mg slow-release capsules,

knowing that Valrelease will assure all the benefits of Valium 5 mg *t.i.d.* with the convenience of once-a-day dosage.

Discontinuation of Valium (or Valrelease) is typically as smooth as its start in short-term therapy. However, Valium and Valrelease should be discontinued gradually after more extended treatment. As you diminish dosage, the built-in tapering action of Valium and Valrelease will help avoid rapidly recurring anxiety symptoms and symptoms of withdrawal, and will help ease the patient's transition to independent coping when therapeutic goals have been achieved.

...that's one of
the unique benefits of
Valium®
diazepam/Roche

Valium® (diazepam/Roche)  Tablets
Valrelease™ (diazepam/Roche)  slow-release Capsules
Injectable Valium® (diazepam/Roche) 

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3; administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity,

insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL Adults: Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.) For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children administer I.V. slowly; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levartanol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

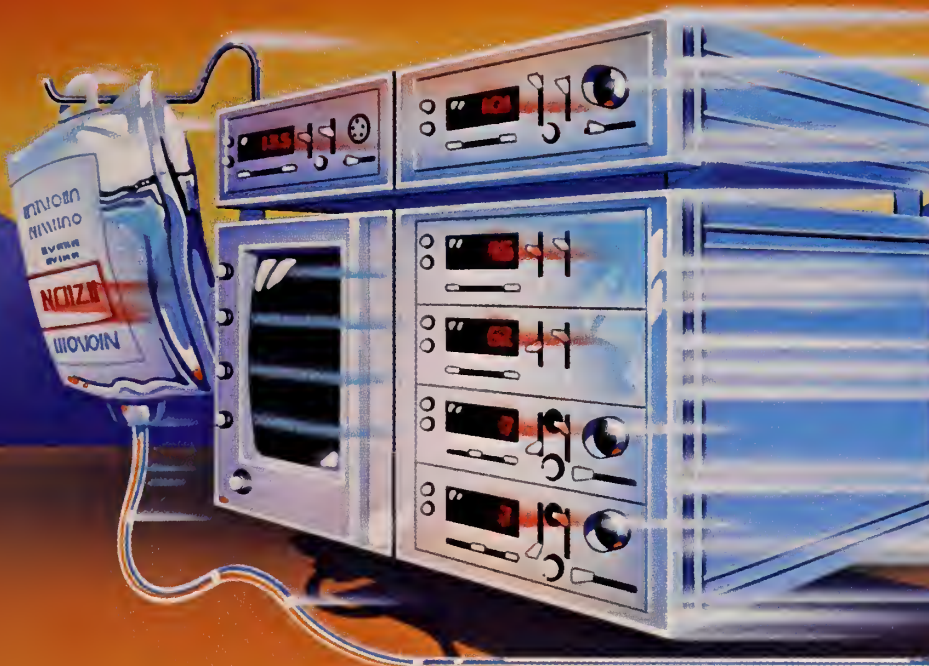
ORAL Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.



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PATHOLOGIST seeks location in Mississippi. M.D., Ohio State University; residency, University of Alabama. Contact Janice Blazina, M.D., 2323 DeLee St., Apt. 31, Bryan, TX 77801.

BOARD CERTIFIED FAMILY PRACTITIONER seeks location in Jackson or Greenville area with established group beginning August 1, 1984. Contact Hernando C. Payne, M.D., 1557-A Eglin Way, Washington, DC 20336.

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FAMILY PHYSICIAN wanted to locate in small town in central Mississippi. Excellent private practice opportunity. Large trade area. Established clinic with all equipment, including x-ray. Call (601) 253-2321. Mayor Grady Sims, Walnut Grove, MS 39189.

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ESTABLISHED GENERAL PRACTICE for sale or rent. Fully equipped, located at Southland Plaza, Louisville, MS. Contact David Wilson, Jr., P.O. Box 205, Louisville, MS 39339; telephone (601) 773-6052.

FULLY EQUIPPED ob-gyn clinic available for immediate occupancy. Trade area of approximately 50,000 persons; modern hospital; no other obstetricians in immediate area. Contact Mr. James Townsend, Administrator, Bolivar County Hospital, Cleveland, MS 38732, or call (601) 846-2550.

COMMUNITY seeks family or general practitioner. Building available for clinic, and county hospital within 10 miles. Contact Bo Robinson, Rt. 1, Box 190, Hamilton, MS 38746 or call (601) 343-8924 at night.

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MISSISSIPPI STATE HOSPITAL has openings for psychiatrists, internists, and general practitioners. Salary negotiable, malpractice paid, CME provided, and housing available. Contact James C. Stubbs, director, Mississippi State Hospital, Whitfield, MS 39193; (601) 939-1221.

INTERNIST — Group of five in a town of 25,000; three board certified and two board eligible in internal medicine. Want a person to replace one of our group who is retiring. Prefer a general internist; but someone with subspecialty training, yet interested in doing primary internal medicine is acceptable. Generous minimum salary guarantee. Send CV and other pertinent information to Dr. D. W. Frederiksen, 2120 Crestmoor Rd., Nashville, TN 37215.

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IN CONCLUSION

Companies offering cardiopulmonary resuscitation (CPR) training should concentrate their efforts on fewer employees and refresh them more frequently, according to a study on CPR skills retention appearing in Annals of Emergency Medicine. Training also should focus on younger employees who have had previous first aid training, the report said. Results of the study showed that in lay basic rescuers, CPR skills had deteriorated to 40% of the post-training level after only one year.

One of the first near-death experiences to appear in medical literature is reported in the October 1983 American Journal of Diseases of Children. The author describes the near-drowning of a seven-year-old girl, reported to be comatose with fixed and dilated pupils when CPR was given at the swimming pool site. Her experience was said to be consistent with the prototype near-death experience in ways that cannot be explained by her religious background, the author said, noting the possible benefits of counseling in such cases.

The dramatic increase in cesarean sections performed in the U.S. during the last decade may be partially responsible for improved survival rates among some high-risk infants, says an article in the October 28 JAMA. The author suggests that neonatal mortality is reduced among all breech-delivered infants and low birth weight infants delivered in vertex position. If neonatal mortality can be shown to decline significantly, the benefits of cesarean section may outweigh the increased risk of maternal infection and deaths, he suggested.

Major depression plus panic disorder in one patient appears to be an important marker for a variety of psychiatric disorders afflicting that patient's near relatives, says an article in Archives of General Psychiatry. "Relatives were more than twice as likely to have major depression, panic disorder, phobia, and/or alcoholism than relatives of probands with major depression without any anxiety disorder," the authors state. Possibility of constitutional predisposition has a bearing on pharmacologic treatment, they add.

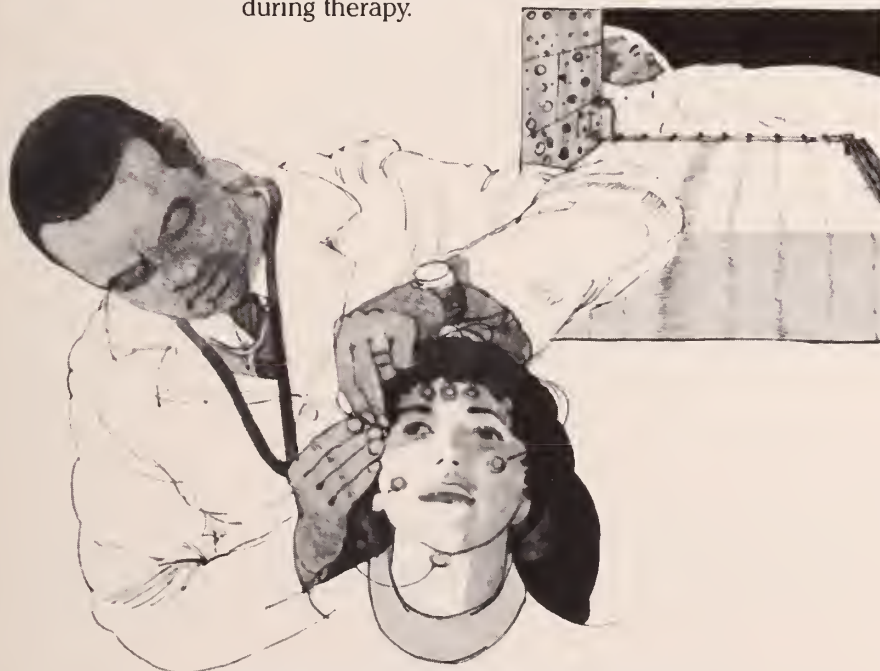
The term "wrongful life" correctly applies to a defective child's cause of action, alleging that the physician failed to inform and advise the parents adequately concerning foreseeable fetal risks from genetic or other congenital defects, points out an AMA attorney in the October 28 JAMA. "Wrongful life actions generally have not received favorable judicial or legislative response," the author stated. She noted that this might change as prenatal testing and genetic counseling become more refined.

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References: 1. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 4. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 5. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Kales JD: *Pharmacol Physicians* 4:1-6, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5:25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The

sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdose, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. **Adults:** 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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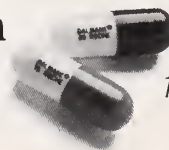
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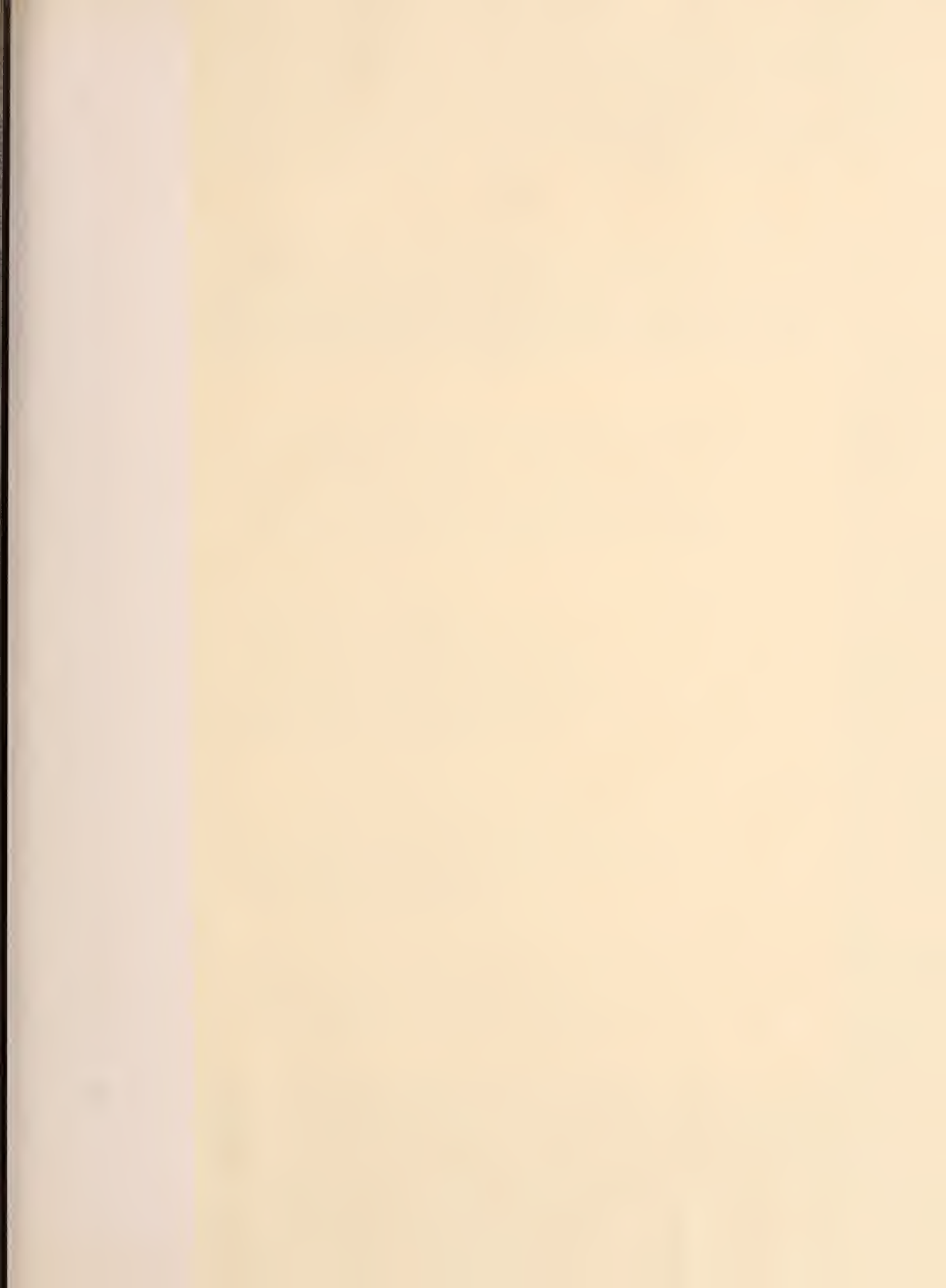
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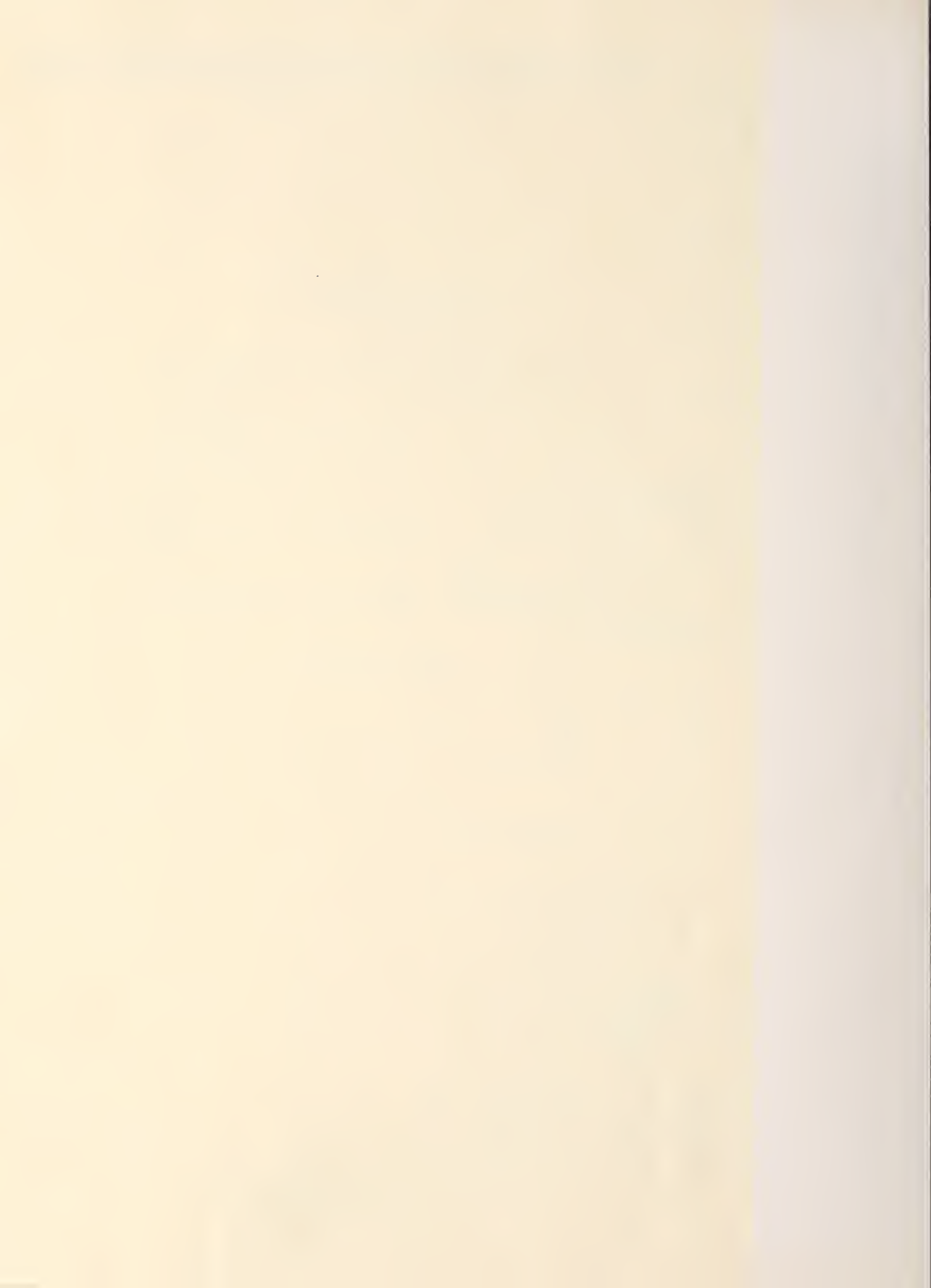


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INDICATIONS: For the treatment of the symptoms of seasonal and perennial allergic rhinitis and vasomotor rhinitis, including nasal obstruction (congestion).

CONTRAINDICATIONS: Hypersensitivity to any of the components, concurrent MAO inhibitor therapy, severe hypertension, bronchial asthma, coronary artery disease, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. Do not use in children under 12 years.

Do not use this drug in patients with narrow-angle glaucoma, obstructive or paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. Do not use in nursing mothers.

Use in treating lower respiratory tract symptoms, including asthma, is contraindicated.

WARNINGS: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients. Patients should also be warned about the possible additive effects of alcohol and other CNS depressants.

Usage in pregnancy: Safe use in pregnancy has not been established. Use only when the potential benefits have been weighed against the possible hazards to the mother and child. Note that an inhibitory effect on lactation may occur.

PRECAUTIONS: Use with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension, hiatal hernia with reflux esophagitis, intestinal atony of the elderly or debilitated patient, myasthenia gravis, renal function impairment, and ulcerative colitis (severe).

Drug Interactions: MAO inhibitors, Alcohol or CNS depressants, especially anesthetics, barbiturates, and narcotics.

ADVERSE REACTIONS: Prolongs the response to nervous stimulation, potentiates the response to norepinephrine, and inhibits the response to tyramine.

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Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

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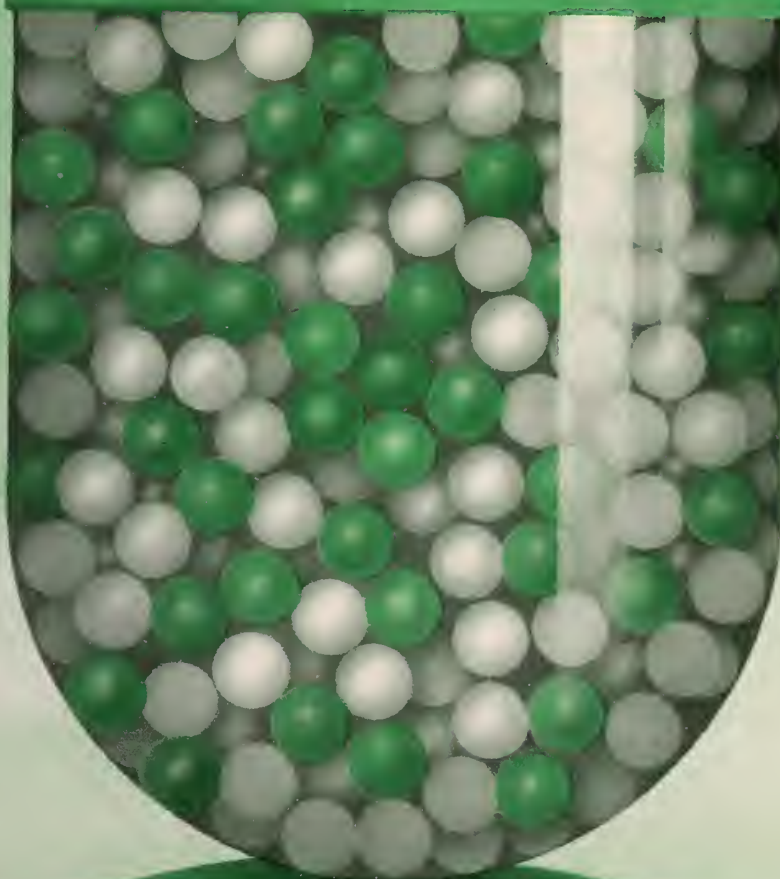
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An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of *Clostridia*. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: General Precautions—If an allergic reaction to Cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the mother's side of Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clintest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in fetuses given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cefclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Cefclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

hour. The effect on nursing infants is not known. Caution should be exercised when Cefclor® (cefclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Cefclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis, arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Dlter effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

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*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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NEWSLETTER

December 1983

Dear Doctor:

Allegations that the health of Americans has deteriorated as a result of modern technology and lifestyle are not supported by national health statistics, says a report, "America's Health: A Century of Progress but a Time of Despair," published by the American Council on Science and Health. Common measures of health status such as life expectancy, infant mortality, death rates, and infectious disease rates all indicate substantial improvement in Americans' health in this century.

The report notes, however, that modifying just three risk factors -- smoking, hypertension, and alcohol abuse -- could have prevented one-third of the 1½ million American deaths from the five leading causes of death in 1979. A complimentary copy of the 31-page report, which includes data on all age groups, is available by sending a stamped (37¢ postage), self-addressed, #10 envelope to ACSH, 47 Maple St., Summit. NJ 07901.

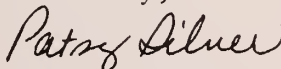
As for the nation's health care system, an increasing number of people are satisfied, according to a survey by Health Insurance Assn. of America. Of those surveyed, 85% reported satisfaction, compared with 82% who gave that response in 1978. The survey also showed that the public believes physicians and hospitals are responsible for increases in health care costs, and that 76% think health costs are rising faster than other costs, compared with 63% two years ago.

Among suggestions for preventing the bankruptcy of Medicare which are now under consideration by a Social Security Advisory Panel are: raising the age for Medicare eligibility to 67; providing a voucher option; requiring all or none assignment by physicians; and establishing a fee schedule for physician services adjusted only for cost of living and cost of maintaining a practice. The panel will hold its final meeting this month.

A reminder: "Comment" is Journal MSMA's forum for membership opinion. This issue features a commentary by immediate past president Sidney O. Graves, M.D., on the issue of physician representation on hospital governing bodies. During the past year Journal MSMA has received several commentaries on a variety of topics. If you have an opinion on a current medical issue, send your comment to your journal office, P.O. Box 5229, Jackson, MS 39216.

The staff and officers of the MSMA extend wishes for a Merry Christmas. May you have a joyous holiday season and a happy and healthy year in 1984.

Sincerely,



Patsy Silver
Managing Editor

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Counsel to Authors

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes

may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for up to four illustration engravings. More are not permitted unless voted on by two editors and extra costs must be absorbed by the author.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript.

Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. — *The Editors.*

In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by all authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*

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DATELINE

Scientific Exhibit Space Available

Jackson, MS - The MSMA is accepting applications for scientific exhibit space at the 116th Annual Session, to be conducted May 16-20 at the Royal d'Iberville

Hotel in Biloxi. Applications should indicate the title of the exhibit, the names of its sponsors, and the estimated number of linear feet it will occupy. Deadline for exhibit applications is January 15. Send your letter of request to Chairman, Scientific Exhibits, P.O. Box 5229, Jackson, MS 39216.

AMA Reports Data on PPOs

Chicago, IL - Preferred provider organizations have attracted 5% of physicians, according to the AMA's Socioeconomic Monitoring System. Of those who have

joined, 60% said PPOs increased their certainty of patient loads, 40% said they reduced out-of-pocket costs for patients, and 27% said they reduced collection problems. Of those who have not joined, 25% said the reason was insufficient reimbursement, and 24% cited extra paperwork as the reason.

Satellite Clinics Increase Competition

Chicago, IL - Freestanding satellite clinics have increased the competition for patients, according to a survey conducted by the AMA's Socioeconomic

Monitoring System. Of the 1,237 physicians interviewed, about 25% said the hospital at which they provided most of their patient care had freestanding satellite clinics. Of these physicians, 26% said they provided care in the clinics and 46% said the facilities had increased competition.

New PMI Sheets Are Available

Chicago, IL - The AMA has published 20 new Patient Medication Instruction sheets, bringing the total to 60. For the first time, the AMA is issuing PMI

sheets for over-the-counter pharmaceutical products other than insulin: anti-histamines used for motion sickness, allergies, and insomnia; bronchodilator aerosols; aspirin; and acetaminophen. Minimum order is 10 pads for \$5, pre-paid to AMA Order Dept., P.O. Box 8052, Rolling Meadows, IL 60008.

Calcium Blockers Relieve Migraine

Chicago, IL - Daily doses of verapamil cut migraine headache frequency by 50% and decreased pain severity when headaches did occur, according to a report in

the November 11 issue of JAMA. There were no major side effects, the researchers said, noting that other medications tend to induce fatigue, depression and respiratory and heart irregularities. In the same issue the Council on Scientific Affairs reports on efficacy of calcium channel blockers such as verapamil.



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ORIGINAL PAPERS

Giant Cell Arteritis Causing Brachial Artery Aneurysm in an Eight-Year-Old Child

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PERIPHERAL ARTERIAL ANEURYSM is rather commonplace in an elderly adult population. The presence of a peripheral arterial aneurysm in a child, however, is distinctly uncommon as is the presence of giant cell arteritis. The subject of this report is an eight-year-old child with a brachial artery aneurysm associated with giant cell arteritis.

J. P., an eight-year-old white male, was noted on initial examination to have a pulsatile mass on the medial aspect of his brachium. His mother indicated that he had had the flu approximately two months prior to the appearance of this mass. At the time of this admission he had no other systemic complaints of malaise, fever, weight loss, or myalgia.

Laboratory data included a hemoglobin of 12.6 gm, hemocrit of 39.1%, WBC of 12,000 with a differential of 69%, neutrophils 27%, lymphocytes, 2% basophils, and 2% monocytes. Admission chest x-ray was within normal limits.

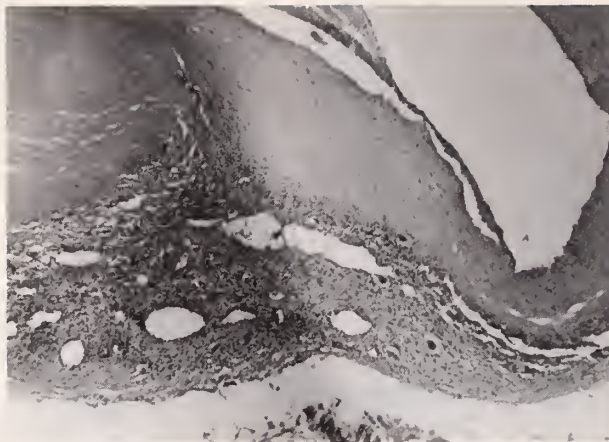
Clinical diagnosis of brachial artery aneurysm of undetermined etiology was made. Surgical exploration was performed. The mass was noted to be a three centimeter aneurysm involving the mid-portion of the brachial artery. The aneurysm was

excised and replaced with a segment of saphenous vein. Both arterial anastomoses were interrupted using 6-0 prolene. Histological examination of the specimen revealed an aneurysmally dilated muscular artery, the wall of which was irregularly thickened. The intima and media were fibrotic. Within the outer portion of the media and portions of the adventitia were collections of lymphocytes and large numbers of multi-nucleated giant cells, consistent with a pathological diagnosis of giant cell arteritis. Post-operatively the patient recovered uneventfully. He has been seen in follow-up one year postoperatively and has had no evidence of further aneurysm formation.

Discussion

Peripheral arterial aneurysm formation in a child is distinctly uncommon. Reported etiologies for peripheral arterial aneurysm in childhood include congenital, trauma, and various arteriopathies including periarteritis nodosa, Takayasu's disease and giant cell arteritis. Giant cell arteritis is also uncommon in children and only rarely causes aneurysms. Giant cell arteritis usually produces narrowing and complete occlusion of the vessels from intimal proliferation. Localized areas of periarteritis and mesarteritis form a localized granuloma. There is focal

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Brachial artery with numerous multi-nucleated giant cells and chronic inflammatory cells in the media and adventitia. Special stains were negative for fungi and acid fast bacilla. (40×, 8 & E stain.)

necrosis of the media and internal elastic membrane with replacement of the necrotic tissue with granulomatous tissue containing lymphocytes, plasma cells, multi-nucleated foreign body giant cells.

Lie¹ et al reported two cases of temporal or giant cell arteritis in children ages seven and eight. In each of these patients the disease was manifest as an asymptomatic nodule and was not associated with any systemic complaints or antecedent febrile illness. McEnery² described a 5½ year old boy who developed giant cell arteritis in his left femoral artery resulting in gangrene and a subsequent amputation. In this patient the development of giant cell arteritis was apparently related to a febrile illness several months prior. Following the amputation his disease process eventually became quiescent.

Gelfant³ reported a two-year-old child with a tho-

racic aneurysm resulting from giant cell arteritis. The child expired shortly after admission from tracheobronchial compression. Wagenvoort⁴ reported two cases of children with multiple aneurysms involving aortic, renal, subclavian, brachial, and carotid arteries. One of these patients died from rupture of a renal artery aneurysm and the other died from a cerebral hemorrhage. In neither of these cases was there a history of antecedent febrile illness.

Our patient differs from the other children with aneurysm formation in that his illness has thus far run a benign course. He had no other laboratory or clinical evidence of systemic disease at the time of resection of the aneurysm and has remained so thus far. From the very limited clinical experience some conclusions may be cautiously drawn.

Summary

There seems to be two potential courses for childhood giant cell arteritis, either fulminant and progressive or benign and self-limiting. An antecedent febrile illness is probably related in at least some cases. Finally, if anatomic discrepancies can be corrected in the benign form, favorable long term outlook is probably to be expected. ★★★

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Suicide Attempt by Toxaphene Ingestion: A Case Report

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TOXAPHENE is an insecticide used primarily on cotton and occasionally on food crops. It is a complex mixture of polychlorinated compounds which is known to cause cancer in mice.^{1, 4} It has an amber, waxy appearance and a mild terpene odor. It is fat soluble, but insoluble in water. Toxaphene is a central nervous system stimulant which, when ingested, can cause convulsions. It has been reported to produce amnesia, probably secondary to seizures. Warning signs and symptoms, such as nausea and vomiting, may or may not occur. Elevation of liver enzymes and decreased renal function may occur.²

In fatal poisoning, convulsions occur at decreasing intervals until respiratory failure supervenes, almost always within 24 hours after the ingestion. A fatal dose for an adult is estimated to be about 2 gms.² Few reports of toxaphene ingestion are found in the literature, and most of those described are due to accidental ingestion by children.³ The following is a case report of a suicide attempt by toxaphene ingestion by an adult.

Case Report

J. P., a 26-year-old black male, was brought by ambulance to the emergency room of the Mississippi Baptist Medical Center. He was accompanied by his mother and brother, who stated that he had had a series of jerky movements followed by a non-responsive state, except for occasional moaning sounds. The only other pertinent history obtainable at this time was that he had "felt bad" earlier that day, but in general had been healthy all his life.

The patient was initially seen by the emergency room physician and found to be in a depressed state of consciousness. The emergency room physician witnessed five seizures which were of the grand mal type. The on-call physician was then summoned. Further history revealed that the patient had had an argument with his girlfriend and had threatened to kill himself.

The patient was a well-developed, well-nourished black male who initially appeared to be in a postictal state but later became disoriented, combative, and generally uncooperative. Physical examination was unremarkable except for dysconjugate eye movements which were not initially present. During the physical examination, the patient experienced another brief seizure.

A white blood cell count was 19,400 with 48% polymorphonucleophils, 5% bands, and 40% lymphocytes. Arterial blood gases revealed a PO₂ of 106 torr, a PCO₂ of 31.5 torr, a pH of 7.007 and a bicarbonate of 7.6. Electrolytes were unremarkable. Toxicology studies on urine and blood were ordered.

The patient was given a loading dose of Phenytoin Sodium (Dilantin)[®], 750 mgs, by slow intravenous push. The low pH and bicarbonate were thought to be due to lactic acidosis secondary to the seizure activity. They responded to NaHCO₃ administration and control of the seizure activity. Gastric aspiration and lavage were performed. Large amounts of material with a peculiar odor were obtained and a sample was sent for toxicology screen. Activated charcoal and a cathartic were given. About this time, other members of the family arrived with an empty 16 ounce bottle of Tox-Sol which had been found in a garbage can at home. The major component of Tox-Sol is toxaphene. The patient was admitted to the intensive care unit for observation and further treatment.

The patient continued to have intermittent seizure activity, relieved by intravenous diazepam (Valium)[®], throughout the night. The next morning he was alert, oriented, and seizure free. However, he felt weak and was unable to move his left upper arm due to pain. His left shoulder felt hot. Laboratory data revealed a uric acid of 26 (nl 1.5-7.0) and gouty arthritis was suspected as the cause of the hot, painful shoulder. His uric acid level peaked at 38, LDH at 7,272 (nl 30-120), SGOT at 2,035 (nl 8-36) and CPK at 192,250 (nl < 20). His initial serum creatine was 0.8 (nl 0.8-1.4), but rose to 2.1, and a urine analysis revealed occult blood, 3+ acetone, amor-

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phous crystals, and 2+ protein. The toxicology screen was positive for toxaphene.

The patient appeared to have amnesia for a period of time three weeks prior to the suicide attempt. He was evaluated by a psychologist and found to be free of depression and without inclination for suicide.

A repeat urine analysis revealed a normal urine. Repeat WBC, LDH, SGOT, alkaline phosphatase, and uric acid were found to have returned almost to normal levels. However, he still complained of pain in his left shoulder. An x-ray revealed an avulsion fracture of the greater tuberosity and a portion of the lateral head of the humerus as well as dislocation of the humeral head. Open reduction was required. He was discharged from the hospital without any sequelae of the toxaphene ingestion, except for the shoulder injury.

Discussion

Convulsions, as occurred with J. P., are characteristic of toxaphene poisoning and consist of tonic-clonic motions due to diffuse stimulation of the brain and spinal cord. Nausea and vomiting usually occur, but may be absent, as in the case of this patient. J. P.'s depression abated following the events of the ingestion episode. He remembered nothing of the argument with his girlfriend or of any of the subsequent events. His loss of memory extended three weeks prior to the ingestion. Amnesia following toxaphene ingestion has been reported.²

Elevation of liver enzymes and compromised renal function are also known to occur following toxaphene ingestion.² Other laboratory abnormalities seen in this case were the high uric acid and CPK levels. These probably resulted from the renal compromise and seizure activity, respectively. J. P.'s high WBC count (19,400) remains unexplained. It was not secondary to infection, but probably to the stress of the events following the ingestion. The shoulder fracture was undoubtedly the result of the seizure activity.

This case exemplifies many of the clinical symptoms and signs of toxaphene poisoning. However, this case differs from most in that it was a planned suicide attempt rather than accidental ingestion.

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Radiologic Seminar CCXXXIV: Lymphoma of the Breast: Case Report

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A 24-YEAR-OLD G5P4 black female noted bilateral multiple breast masses in the third trimester of pregnancy. She subsequently delivered a 32-33 week fetus in May 1983. She failed to return for breast biopsies but returned to the emergency room the next month with chest pain and shortness of breath. Radiographs revealed a right pleural effusion and mediastinal mass (see Figure 1). Pleural fluid and pleural biopsy led to treatment with penicillin of a presumed inflammatory process. The patient failed to return for recommended chest CT scan of the mediastinum and breast biopsies.

She again presented to the emergency room in August 1983 with back pain. Pleural fluid, breast lumps, and mediastinal mass had persisted. At this time work-up progressed and the patient was found to be pregnant. Lymphocytic infiltration of skeletal muscle on pleural biopsy was noted. The patient was scheduled for termination of pregnancy to follow breast biopsy. Mediastinoscopy had revealed only "anthracosis" (see Figures 2 and 3). Breast biopsy of a representative mass revealed malignant lymphoma, large cell type (New International Formulation) or diffuse histiocytic (Rappaport). The dilatation and curettage were complicated by perforation of the lower uterine segment; emergency hysterectomy revealed pathological diagnosis of lymphomatous infiltration of the uterus, multifocal. The fetus was about 12 weeks gestational age. Further work-up revealed normocellular marrow. The patient was discharged for a brief stay at home; she developed a compression fracture of T8 before her scheduled admission but has failed to return for completion of work-up as of this writing.



Figure 1. Chest PA erect radiograph demonstrates right basilar infiltrates and fluid. Superior mediastinum is too wide for a normal 24-year-old woman.

Discussion

Lymphoma of the Breast: Due to the patient's status upon presentation and diagnosis, it will never be known if she had primary or metastatic lymphoma of the breast. Although metastatic lymphoma of the breast is a common metastatic lesion to the breast, primary lymphoma of the breast is an uncommon malignancy. The incidence of primary lympho-

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ma of the breast is estimated to be 0.12% of all malignant breast tumors and 20% of breast sarcomas. A somewhat more rapid growth and absence of nipple discharge differs from the clinical signs and symptoms of breast carcinoma, but the age range and sex are similar.¹

Although primary malignant lymphoma of the breast usually only heralds the generalized disease, the interval before it manifests itself may be from a few months to many years. Sometimes local recurrence of the disease leads to severe morbidity without any evidence of dissemination.² Ross and Eley state that the outlook is better in lymphosarcoma than carcinoma.³

Diffuse histiocytic lymphoma of the breast as in this case and diffuse poorly differentiated lymphoma of the breast tend to be associated with an unfavorable prognosis. Suspicion has been raised by a few authors that many long-term survivors actually may not have been the victims of malignant lymphoma, but possibly of pseudolymphoma, an entity associated with trauma in three of five patients in one series.^{4, 5}



Figure 2. Scout radiograph for the CT scan demonstrates level of slice in Figure 3.

Pregnancy and Breast Lymphoma: Wiseman reports a review of 16 cases of primary lymphoma of the breast in which two cases were associated with pregnancy. Both delivered healthy babies. One case only underwent local excision and apparently was disease free at one year, but was lost to follow-up thereafter. The other patient had regional node involvement and died three months later.⁶

The case report above was not felt to be a case of Burkitt's lymphoma. In a 16-year review of 703 cases of African female breast cancer, seven cases were found in pregnant women and another seven cases in lactating women.⁷ Five of the 14 cases were lymphosarcomas. There were three cases of bilateral Burkitt's lymphoma and two cases of large cell lymphoma. All five of these were found in lactating women. The remaining nine patients in the series had tumors arising from mammary tissue proper. Based on their data and a review of the literature, the authors make the point that the most important histologic types of malignant breast lesions found in pregnancy and lactation in African women are the malignant neoplasms of reticuloendothelial origin, particularly Burkitt's lymphoma and reticulum cell sarcoma. Although these cases typically present clinically as breast tumors, they were soon found to have disseminated lymphoma with subsequent rapid death.

In America, Burkitt's lymphoma of the breast is uncommon. There is a report of a single case in 32-year series of 14 cases of primary malignant lymphoma of the breast. In that case there was bilateral breast enlargement three weeks postpartum, and the patient died nine months following diagnosis despite intensive chemotherapy. The clinical aspects of that case were similar to those of Burkitt's in African lactating women.¹ A review of 30 cases of American Burkitt's lymphoma at the National Cancer Institute revealed none with presentation in the breast.⁶ Similarly, only two of 114 confirmed cases of American Burkitt's lymphoma presented with initial breast involvement, although there may have been disseminated disease even in these cases.¹

Mammographic and Physical Findings in Lymphoma or Metastases to the Breast: Our patient had a mammogram (see Figure 4); the pattern in this case was nonspecific but demonstrated dense breast parenchyma with multiple masses. This can be a fairly common pattern in young women with fibrocystic disease, but ultrasound demonstrated that none of the lesions were cystic.

In McCrea's report of varied breast metastases, mammography was positive in all but three patients who were either pregnant (two) or immediately post-

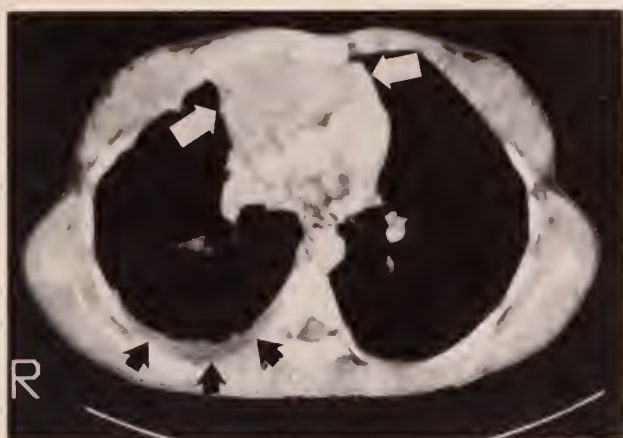


Figure 3. Cross section CT scan at the level indicated in Figure 2. Note the pleural fluid layering posteriorly (black arrows) and the large mediastinal mass (white arrows).



Figure 4. Mediolateral mammogram of the left breast demonstrates very dense tissue. Vaguely defined soft tissue masses are suggested throughout the breast. Black arrows point to one. White arrow marks level of nipple.

partum (one). Breast parenchyma is very dense during pregnancy and lactation, a definite limiting factor for mammography. Interestingly, their diagnoses were acute lymphocytic leukemia, diffuse histiocytic lymphoma, and acute myelocytic leukemia. The association between pregnancy or lactation and a hematogenous metastatic lesion is not clear in this series.⁸

Bohman's series states that mammographic findings in various histologic metastatic foci to the breast usually appear as circumscribed spheroid shadows with only slightly irregular margins and without the calcifications and desmoplastic response that characterize many primary scirrous breast carcinomas, which are 90% of primary breast tumors.⁹ Only rare cases of metastatic ovarian cancer to the breast have been shown to demonstrate calcifications.^{9, 10} In Bohman's series there was close correlation between palpable size and size at mammography except in one case in 14, that being an undifferentiated lymphoma.

Schouten et al reviewed previous reports and found a predominance of right breast lymphomatous involvement by a ratio of 76:40. Primary breast carcinoma is more often in the left breast. He also found that 13% of the 176 patients reviewed presented with bilateral lymphoma of the breast and an additional 9% developed metastases to the opposite breast.¹¹ He suggests mammography can be a useful parameter in following the opposite breast in these patients.

In another review of metastasis to the breast, lymphoma (primary or secondary) of the breast was seen

on mammography, variably as discrete to ill-defined masses and sometimes even obscured by underlying benign and proliferative changes.¹⁰ In McCrea's series of 16 cases of metastases to the breast the primary malignancies were: four lymphomas, four leukemias, three lung carcinomas, one cholangiocarcinoma of the liver, one squamous cell carcinoma of the left tonsil, one malignant mesothelioma, one pancreatic adenocarcinoma and one highly anaplastic adenocarcinoma (origin from lung, cervix, or breast). Forty percent had no history of malignancy at the time of detection. There was a left to right breast involvement ratio of 7:5. Bilaterality was noted in one of the four lymphoma patients, in two with leukemia, and one with adenocarcinoma of the lung. Three patients had nodular lesions suggesting benign disease. Diffuse skin thickening suggestive of inflammatory carcinoma of the breast was noted in four of sixteen patients in McCrea's series.

Metastases to the breast are often superficial,

sharply limited, solitary masses on physical examination.¹² Some authors report usual absence of pain and discharge. In a report of 51 cases by Hajdu, pain and discomfort were present in more than half the patients. His series also reports attachment of the tumors to the skin in about half of the cases. Chest wall adherence is usually absent.^{8, 12} Nipple discharges are also usually absent due to extraductal location of these malignancies. ★★★

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Accreditation Issues

JOHN E. AFFELDT, M.D.

Chicago, Illinois

THE 1984 *Accreditation Manual for Hospitals (AMH)* becomes effective for accreditation decision purposes on April 1, 1984. Several major standard changes have been made in this *Manual*. These changes include the appearance of new, revised chapters pertaining to the "Governing Body" and "Management and Administrative Services." In addition, a new quality and appropriateness standard for clinical support services has been incorporated into 14 chapters, and new standards for hospital-based psychiatric and substance abuse services have been integrated into the manual.

The "Governing Body" and "Management and Administrative Services" chapters of the 1984 *AMH* have been completely revised and are the first standards to appear in a new, simplified format. This new format, which will be used for all future *AMH* revisions, is in outline style, and consists of the statement of general standards followed by required characteristics, which will be used as "performance indicators" to measure hospital compliance during a survey. The previous "Interpretation" section of the 1983 *AMH* has been deleted or incorporated into the required characteristics. Thus simplified, the standards focus only on elements that are essential to the provision of quality patient care.

A new quality and appropriateness standard for clinical support services appears in the *AMH* chapters pertaining to special care units and to anesthesia, dietetic, emergency, home care, hospital-sponsored ambulatory care, nuclear medicine, nursing, pathology and medical laboratory, pharmaceutical, radiology, rehabilitation, respiratory care, and social work services.

The new standard addresses all clinical support services in a common language and emphasizes the importance of each service establishing an ongoing,

This article discusses major changes appearing in the 1984 Accreditation Manual for Hospitals, published by the Joint Commission on Accreditation of Hospitals.

systematic process for monitoring and evaluating patient care problems. In developing this standard, the JCAH eliminated previous frequency requirements as well as other prescriptive language. The purpose of this new standard is to allow hospitals greater flexibility in conducting QA activities, a goal that is in keeping with the intent of the original QA standard, first published in 1979.

The 1984 *AMH* also contains a new unified set of standards for hospital-based psychiatric and substance abuse services, which provides a consistent framework for reviewing all hospital-based psychiatric and substance abuse units regardless of their size. Previously, two different sets of standards were used to evaluate hospital-based psychiatric and substance abuse services. Freestanding psychiatric hospitals and general hospital psychiatric units with 100 beds or more were surveyed under the *Consolidated Standards Manual (CSM)*. Psychiatric units with fewer than 100 beds in general hospitals, on the other hand, were surveyed under the *AMH*, which contained no special standards for mental health services.

For a three-year period, beginning April 1, 1984, the chief executive officers of freestanding psychiatric and substance abuse hospitals and general hospitals offering psychiatric and substance abuse services will have the option of being surveyed under either the *AMH* or the *CSM*. This transition period will allow the staffs of facilities previously surveyed under the *CSM* to familiarize themselves with the *AMH*. The "General Administrative Policies and Procedures" section of the 1984 *AMH* provides new

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ACCREDITATION ISSUES / Continued

criteria for survey eligibility under this *Manual*.

In addition to mentioning the previous standards changes, it should be noted that in August 1983, the JCAH Board of Commissioners approved a draft of the "Medical Staff" chapter of the *AMH* for a fourth field review. About 4,500 copies of the proposed standards were mailed to the field for review during August. The purpose of this field review was to ensure that all appropriate JCAH constituents had an opportunity to comment on this draft of the standards before they were sent to JCAH's Standards-Survey

Procedures Committee for review in November. If this committee approves the draft, the standards will be referred to the Board this month for possible adoption and implementation in 1984.

These standards are the first to be revised as part of JCAH's project to rewrite all of its hospital accreditation standards. The goal of this project, which was initiated in 1981, is to make the standards more flexible, less prescriptive, and more goal-oriented. During 1984 and 1985, the JCAH plans to address revisions of its standards for building and grounds safety; quality assurance; nuclear medicine, radiology, and rehabilitation services. ★★★

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Mississippi Disability Determination Services has need of physicians to serve as consultants to medical examiners. This is a part-time position. The basic requirements are: 1) an unencumbered license to practice medicine in Mississippi and 2) facility in the English language. Those interested should call Mrs. Deborah Warriner, Medical Staff Coordinator. WATS-1-800-962-2230, Extension 2153; Jackson, 922-6811, Ext. 2153.

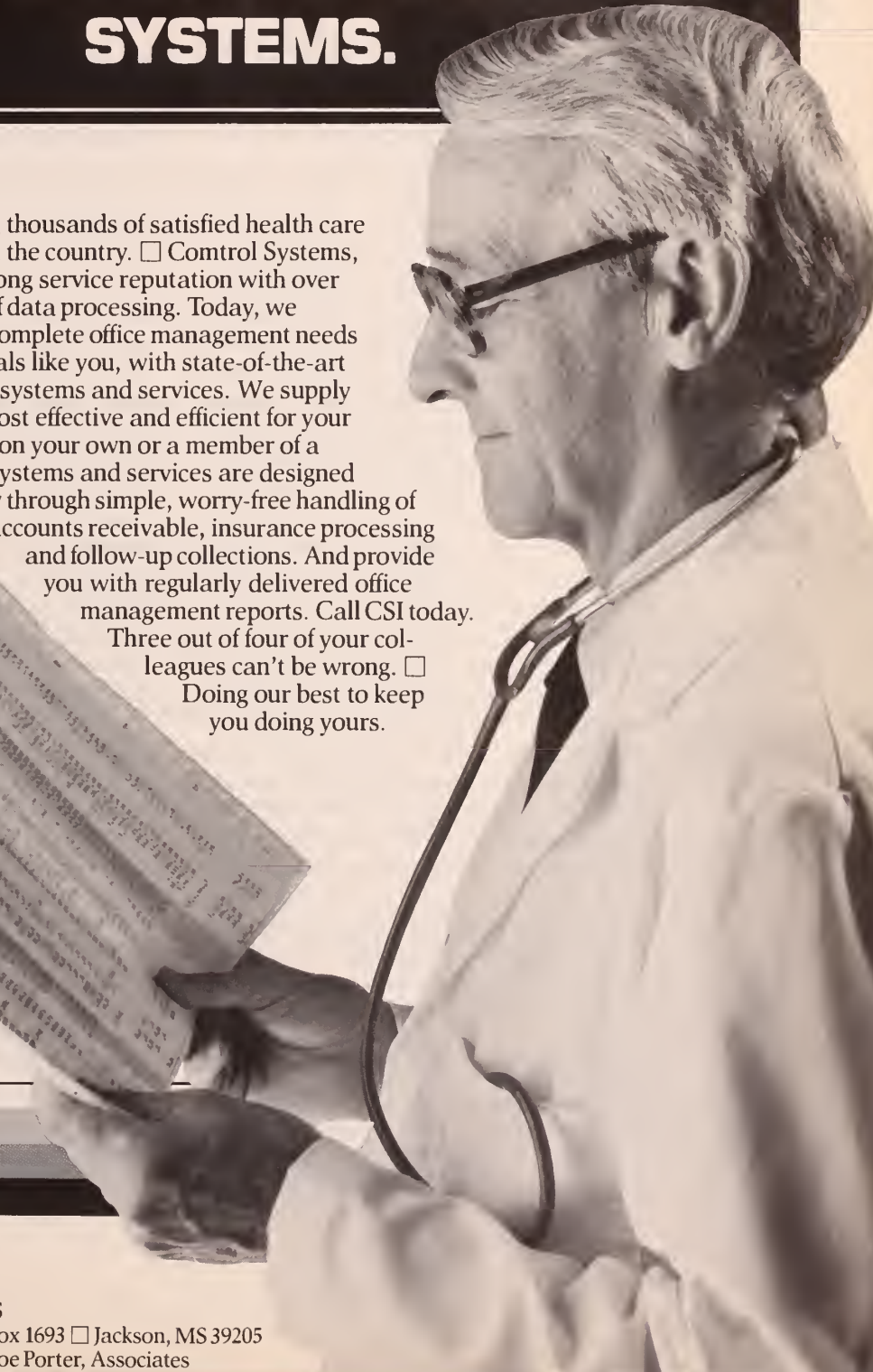
Physicians interested in doing consultative evaluations (according to Social Security guidelines) should contact either Ms. Catherine Hughes (Ext. 2275) or Mr. Henry Klar (Ext. 2276).

The DDS now has a program available for medical society meetings and hospital staff meetings. The purpose of this program is to explain how the disability determination process works, its historical background, its basis in legality and its documentation requirements. Any group interested in this presentation should contact John S. Barr, M.D., Ext. 2277.



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The President Speaking

MSMA Night Before Christmas

Whitman B. Johnson, Jr., M.D.
Clarksdale, Mississippi

'Twas the night before Christmas, and all through the place,
Not a creature was present, not even one face.
The computers were quiet, not making a noise,
'Cause all had gone home, both the girls and the boys.

These "children" were nestled all snug in their beds,
While solutions to problems all danced through their heads.
Charlie was thinking just what he could do
To stop everyone beating his L.S.U.

Bucky was hoping, if you will take note,
What he could do to get the Congressional vote.
Addie and Kay could be left alone
If only us members wouldn't call on the phone.

Cody was hoping, when planning the feedings,
They'd come off as well at Primos, as well as the meetings.
Patsy was praying, and this it must rhyme,
I'd get my "Page" to her office on time.

The media coverage and the government rap
Won't let anyone take a very long nap.
They make such a noise and make such a clatter
It's hard to determine just what's the matter.

They want competition and to lower the cost,
But if they get both, then quality's lost.
Someone must tell them to pick and to choose
Or progress, access, and patients will lose.

When playing the game of "King of the Hill,"
And everyone shoves at you as much as he will,
Then you must know you'll lose the top spot
Unless you come down a step and give them "a shot."

So let's take a lesson from our growing up days,
Get our team together, and make up some plays,
Stop being the scapegoat, come out in the sun,
Show them and our patients what has to be done.

The lawmakers, the public, and we must take note
Of the facts of economy when we go to vote.
And all must consider without much of a pause,
There ain't no free lunch and no Santa Claus.

So the Board in its wisdom, and the officers too,
Want me to wish Merry Christmas to you.
And Kathryn and I, who both need a rest,
Hope in the coming New Year, you all have the best.

★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXIV, Number 12

DECEMBER 1983

The Political Arena

I knew it! I knew it! I knew it all the time. Politics is dirty. Deep down I've always thought so. These events in the waning gubernatorial campaign have brought all my careful doubts bubbling to the surface.

Years ago I had the rather ingenuous idea that the practice of medicine was above the reaches of political chicanery — and I mean completely, totally untouchable. We, on our healing path, had no need for involvement in the manipulations of the smoke-filled room. Then on the long drive home from Centreville and the graciousness of Dick Field and cohorts (this was in 1973, remember) I had my indoctrination course, administered (skillfully, I will admit) by our knowing, bald-headed exec! Big Jim would have been proud, for he expounded the fallacy of separating ourselves from the political arena with a convincing finesse that *almost* had me convinced we should jump right in the quagmire and mud-wrestle these jokers. I offered all my protestations, weakening steadily as we rolled northward.

I finally acquiesced, accepting over the years the need for our involvement, accepting almost eagerly the PACs, financial support of candidates, a full-time lobbyist, etc., etc. I relished each small victory, even gloating a little when a bill we supported passed, but knowing that we always seemed to lose the big ones — like the licensing of the bone-crackers (in spite of the efforts of our then lobbyist, the bald-headed exec himself) and turning the optometrists loose (in spite of the efforts of the irrepressible Bucky, who may well have been born in a smoke-filled room!).

Maybe, just maybe, if we could by some miracle resume our past posture, unbesmirch our tarnished image, and climb back up on the pedestal we occupied for so long, then in my Utopian dream we would be back above political machinations. Knowing this could only happen by an almost complete

turn-around in attitudes, dedication, feelings and relationships, I realize how unlikely a dream it is, but at least I can dream, can't I?

ARTHUR A. DERRICK, JR., M.D.
Associate Editor

Impressions of Canadian System

Canada is a beautiful country and impressive with the cleanliness and the pride of its citizens.

While attending recently an interesting medical seminar on Canada's west coast, and enjoying the gardens of Victoria and the delightful climate and the scenery of the Canadian Rockies, I had the opportunity to converse with several Canadian physicians. I was not impressed that they were a disgruntled or unhappy lot; but without exception they were adversely critical of the system and felt that they were poorly compensated.

As you may or may not know, Canada has total health care: Everyone is on Medicare and the patient is liable only for his drugs. Of the several patients with whom I talked, all felt that doctors were well paid and were themselves totally pleased with the system. On more than one occasion laymen felt that doctors were greedy, and an editorial in the Vancouver newspaper accused anesthesiologists of just this, when they voiced their demand for more compensation.

Canada furnishes total health care with 7½% of its GNP, while ours probably exceeds 10% at this time.

It would be interesting to know what a survey of public opinion on health care in the United States would show.

In Canada both patients and physicians feel that quality care is provided. Sometimes elective procedures are delayed, but I talked with no one who considered this a problem.

There is an appreciable segment of our society

which is not adequately covered for medical benefits, and which, if covered, would extend health care costs well beyond the 10% under our system.

It is surprising on occasion to see how much less care is "needed" by those not able to pay and not covered by a third party.

Canada has fewer physicians, proportionally, than do we. It is only logical to assume that under these conditions fewer procedures of questionable necessity will be done.

W. MONCURE DABNEY, M.D.
Editor Emeritus

COMMENT

Importance of Physician Representation

What could be more natural than a physician serving on his hospital governing board? Who is better qualified to act as a liaison between the medical staff and the policy setting group? Is it possible that a Dr. Jones sitting as an equal member on a hospital governing board would do anything but improve the function of that hospital? I believe that the average person (and doctors are people) expects a physician representative on the hospital board.

And yet — there are 15 general acute case hospitals licensed in this state, and only 40 of them have physicians on their governing boards.

Why is this? Do the authorities who choose board members really think that a physician is going to hamper the function of this board? Such a thought is ridiculous.

Let me tell you about the Natchez experience. In 1971 there was much internal strife and conflict at the Jefferson Davis Memorial Hospital in Natchez. The conditions were impossible. As a result of an enabling act by the legislature, the Board of Trustees was abolished. Various members of the staff met with the Board of Supervisors of Adams County and urged them to appoint a physician on the new board. We were successful in our efforts, and a doctor was appointed and served for one year. After the first year, a second doctor was appointed, who served a three-year term. Since then, a different doctor has been appointed every three years to serve on the board. The Homochitto Valley Medical Society has a bylaw which prevents a doctor from serving more

than one three-year term. Several of the physician trustees have served as chairman of the board. This hospital has functioned as smoothly as any comparable hospital could since early 1972. There could be no better relationship than that that exists between the medical staff and the governing body here.

We also have a 100-bed privately owned hospital — the Natchez Community Hospital — and there are four doctors on that governing board.

So, my question is why don't all the hospitals in Mississippi have a physician on their governing boards!

One of the presidential recommendations at the last MSMA House of Delegates meeting was that doctors throughout the state make every effort to encourage hospitals to include a physician as a member of their governing board; and by that, we don't mean an ex officio member, but rather a voting member. This recommendation was approved and adopted by the House of Delegates.

Hopefully, some action has been taken by some of you at the hospitals which are not "in compliance." Let me quote from the 1983 *Accreditation Manual for Hospitals* from the Joint Commission on Hospital Accreditation: "When not legally prohibited, physicians who are members of the Medical Staff shall be eligible for and should be included in full membership on hospital governing bodies in the same manner as are other knowledgeable and effective individuals." From this you can see that such non M.D. governing board hospitals actually are not in compliance with the joint commission recommendations. Why don't each of you bring this to the attention of both the chairman of your hospital board and your executive director?

It really shouldn't be necessary to coerce your board into taking a member of the staff into the governing body. We are in a period of vast changes in which cooperation between the staff and the board is more badly needed than at any time in our past. The DRG reimbursement fiasco is going to require maximum cooperation from both hospitals and doctors. An M.D. board member could facilitate this. We all have concerns over increasing hospital costs. The same applies here as it does to the DRG problem.

When will we find a better time to get both doctors and hospitals interested in the idea of physician representation on hospital governing boards? Take this first step now. Talk to your Board of Supervisors and your hospital governing board. Do it!

SIDNEY O. GRAVES, M.D.
Suite 7, Medical Arts Building
Natchez, MS 39120

MEDICAL ORGANIZATION

1984 MSMA-Robins Award Nominations Announced

The 23rd annual Mississippi State Medical Association-Robins Award for outstanding community service by a state physician has been announced to the component medical societies by the Board of Trustees. The 1984 award will be presented at the 116th Annual Session.

Each component society has been invited to submit a nomination for the honor. Deadline for nominating letters is January 3, 1984. The Board of Judges, consisting of the MSMA vice presidents, will review the nominations.

The award is sponsored annually by the association and the A. H. Robins Company of Richmond, VA. The series was instituted in 1962, and the award consists of a sculptured bronze plaque in bas-relief, engraved, and mounted on a mahogany panel.

The 22 Mississippi physicians who have received the high honor are: Dr. Thomas G. Ross of Jackson; Dr. Frank M. Davis of Corinth; Dr. Howard A. Nelson of Greenwood; Dr. Maura J. Mitchell of Ellisville; Dr. J. T. Davis of Corinth; Dr. Frank M. Acree of Greenville;

Dr. W. H. Anderson of Booneville; Dr. Omar Simmons of Newton; Dr. W. J. Aycock of Calhoun City; Dr. Walter H. Rose of Indianola; Dr. Reginald P. White of Meridian; Dr. W. A. Long, Jr., of Jackson; Dr. Virginia S. Tolbert of Ruleville; Dr. Thomas M. Davis of Jackson;

Dr. Thomas G. Barnes of Greenville; Dr. Hugh Banks Barnes of Hattiesburg; Dr. Verner S. Holmes of McComb; Dr. W. L. Jaquith of Whitfield; Dr. Jack Atkinson of Brookhaven; Dr. W. Lamar Weems of Jackson; Dr. John G. Caden of Jackson; and Dr. T. F. McDonnell of Hazlehurst.

Panelists Discuss High Blood Pressure Control



State Health Officer Alton B. Cobb, M.D., second from right, joined workshop panelists who discussed "compliance with blood pressure control programs; role of exercise and stress management" at the Ninth Annual Southeastern High Blood Pressure Conference. Panelists were, from left, Patricia M. Dubbert, Ph.D., project director for the Cardiovascular Risk Modification Program, VA Medical Center in Jackson; Thomas F. Gillette, M.P.H., coordinator of hypertension services for the South Carolina Department of Health and Environmental Control; and John E. Martin, Ph.D., director of the Behavioral Medicine Program at VA Medical Center, Jackson. Co-sponsors with the Mississippi State Department of Health were the American Heart Association — Mississippi Affiliate, Inc., Kidney Foundation of Mississippi, Mississippi Nurses Association, National High Blood Pressure Education Program, and the Division of Continuing Health Professional Education — the University of Mississippi Medical Center.

Biloxi Will Host Tri-State Thoracic Conference

Twenty-four speakers from medical centers throughout the United States will be featured at the 28th annual Tri-State Thoracic Case Conference to be held January 13-14, 1984 at the Biloxi Hilton Hotel. The two-day event is co-sponsored by the Lung Associations and Thoracic Societies of Mississippi, Alabama and Louisiana and the University of Mississippi School of Medicine. Dr. William C. Pinkston of Jackson is conference chairman.

Dr. Marvin I. Schwarz, Associate Professor of Medicine, University of Colorado and Chief, Pulmonary Section, VA Hospital, Denver, Colorado, will deliver the keynote address.

Physicians interested in further information should contact the Mississippi Thoracic Society, P.O. Box 9865, Jackson, MS 39206.

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PERSONALS

JAMES ACHORD of UMC was guest speaker at the recent American Cancer Society meeting in Gulfport.

WILL K. AUSTIN of McComb has been elected chief of staff at Southwest Mississippi Regional Medical Center. B. THOMAS JEFFCOAT is secretary-treasurer.

PAT BARRETT of Jackson presented a scoliosis screening workshop recently for the McComb Junior Auxiliary.

VERNON A. CHASE of Baldwin has been recertified as a diplomate of the American Board of Family Practice.

ROBERT COOPER of Oxford has been recertified by the American Academy of Family Physicians.

CARL EVERS of UMC was an accreditation site visitor at the University of Tennessee Center for the Health Sciences in Memphis.

LUTHER FISHER of UMC made a presentation at the recent meeting of the American Academy for Cerebral Palsy and Developmental Medicine in Chicago.

THOMAS FLORES of Bay St. Louis was recently named chief of staff at Hancock General Hospital.

ALAN FREELAND and JAMES HUGHES of UMC were co-chairmen of a recent course on small fragment fixation of the hand and wrist at Sea Island, Georgia.

RICHARD L. GEORGE of Columbus was recently recertified as a diplomate of the American Board of Family Practice.

JOHN GIBSON of UMC recently spoke to members of the New Orleans Ultrasound Association at Oschner Foundation Hospital.

ARMIN HAERER of UMC presented a paper at a recent meeting of the Society of Clinical Neurologists in Santa Fe, New Mexico.

JAMES HARDY of UMC spoke to members of the Delta Medical Society recently.

VERNER HOLMES of McComb has been inducted into the University of Mississippi Alumni Hall of Fame.

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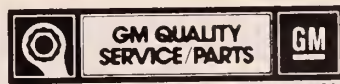
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PERSONALS / Continued

FRANK B. HAYS, JR. announces the opening of his office for the practice of internal medicine at 1203 Second Avenue North in Columbus.

JOSEPH E. JOHNSTON of Mt. Olive has been recertified as a diplomate of the American Board of Family Practice.

WALTER E. JOHNSTON, JR. of Vicksburg has been recertified as a diplomate of the American Board of Family Practice.

HERBERT LANGFORD of UMC was invited by the Heart, Lung and Blood Institute to participate in a "Working Conference on Coronary Heart Disease in Black Population" in Bethesda, Maryland, recently.

CHESTER W. MASTERSON of Vicksburg has been named to the board of trustees of Vicksburg Medical Center.

LYNN B. McMAHAN was a speaker at Southern Medical Association's 77th Annual Scientific Assembly in Baltimore, Maryland, last month.

JAMES U. MORANO has associated with Radiology of Tupelo, P.A., for the practice of radiology.

WILLIAM NICHOLAS of UMC spoke at the recent Diabetic Seminar in Boca Raton, Florida, and at a seminar sponsored by the American Diabetes Association in Columbus.

BARRY S. SULLIVAN has associated with Cleveland Clinic, P.A., for the practice of internal medicine.

DAVID THORNHILL of Gloster recently received a Certificate of Appreciation from the Mississippi Academy of Family Physicians in recognition of his being a charter member of the academy.

L. D. TURNER has been recertified by the American Academy of Family Physicians.

THOMAS B. WALDEN of Brookhaven announces the association of VIJAYA L. DHANNAVADA for the practice of anatomic and clinical pathology at King's Daughters Hospital in Brookhaven.

Scientific Exhibits

Applications are now being
accepted for
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for

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Annual Session
May 16-20, 1984
in Biloxi**

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MSMA
P.O. Box 5229
Jackson, MS 39216

(Your letter of request should include title of exhibit, names of exhibitors, and number of linear feet the exhibit is expected to occupy.)

DEATHS

CRAWFORD, JOHN A., Louisville. Born Philadelphia, MS, July 13, 1899; M.D., University of Tennessee Center For Health Sciences, Memphis, 1926; interned, Baptist Hospital, Memphis, one year; member of East Mississippi Medical Society; died October 16, 1983, age 85.

CURRY, MAX A., Biloxi. M.D., Louisiana State University School of Medicine, New Orleans, 1953; interned Charity Hospital, New Orleans, one year; pediatric residency, same, 1954-56; died October 8, 1983, age 55.

STORK, URBAN F. D., Waveland. Born Darmstadt, IN, January 19, 1907; M.D., Indiana University School of Medicine, Indianapolis, 1930; interned Milwaukee Hospital, Milwaukee, WI, one year; died September 20, 1983, age 76.

Medicolegal Brief

Dentist Cannot Administer Anesthesia For Nondental Purposes

A dentist was not permitted to administer anesthesia for nondental purposes, the Washington Supreme Court ruled.

The dentist completed a 33-month residency program in anesthesia at a state university medical school. The residency program was the same one completed by graduates of medical school who wished to specialize in anesthesiology. He completed his residency in 1970, and was appointed an assistant professor in the department of anesthesiology at the university medical school. He taught general anesthesiology to both medical and dental students and administered all types of anesthesia to dental and nondental patients. He was particularly known for his expertise in anesthetizing infants for open-heart surgery.

In late 1977, the dentist inquired whether he was authorized to sign Medicare forms for reimbursement of his services as an anesthesiologist. In January 1978, the state Attorney General's office informed him that his license to practice dentistry did not authorize the administration of anesthesia for nonmedical purposes. The university then limited his practice to dental patients only, and he filed suit to clarify the meaning of the Dental Licensing Act.

On appeal from summary judgment against him, the dentist contended that he was permitted to engage in any practice included in the curricula of an approved dental school. The court noted that a 1982 amendment to the Medical Practice Act clearly permitted a dentist who had completed a residency in anesthesia to administer general anesthesia. However, the dental licensing act in effect in 1978 did not permit a dentist to administer anesthesia to nondental patients. To hold otherwise would permit all dentists to engage in the general practice of anesthesiology, a practice for which they were not all qualified, the court said.

For purposes of his claims against the university for damages, he was not authorized to administer general anesthesia prior to the date of the 1982 amendment. — *Everett v. State of Washington*, 661 P.2d 588 (Wash.Sup.Ct., April 7, 1983)

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IN CONCLUSION

Cigarette smoking slows blood flow to the brain and is also the leading risk factor for heart attack in women under 50 years of age, according to two reports in the Nov. 25 JAMA. Compared to nonsmokers, cigarette smokers (those who smoke more than one pack per day) experience a seven percent decrease in blood flow to the brain. This deficit increases the risk for stroke, the article says. "The relative risk of MI increased with the amount smoked," the authors report, and the risk was ten times that of women who never smoked.

The majority of persons with serious psychiatric disorders may not be receiving appropriate treatment, according to an article in the Nov. Archives of General Psychiatry. Findings in a survey of 3,161 non-institutionalized adults showed that 69% of persons with major depression and 62% of persons with generalized anxiety used no psychotherapeutic medications. "Among patients who do present themselves to the medical system, usually in primary care settings, these disorders often go unrecognized," the author stated.

Propranolol not only reduces mortality in heart attack victims but also prevents subsequent attacks, according to a multicenter report appearing in the Nov. 25 JAMA. Researchers studied 3,837 patients for more than two years and found that "the incidence of both definite and definite plus probable nonfatal reinfarction was less in the propranolol group than in the placebo group." The study showed that other manifestations of heart disease did not change significantly. Both groups of patients experienced a similar incidence of angina.

The use of lithium salts to treat manic-depressive syndromes is commonplace, despite transient neurological side effects. New research has shown that certain patients may be particularly susceptible to lithium and could end up with brain damage after using the drug. According to the Nov. Archives of Neurology, certain individuals' adverse reactions to standard lithium regimens suggests that individual drug susceptibility, and not inappropriately high dosage, may precipitate neurological damage.

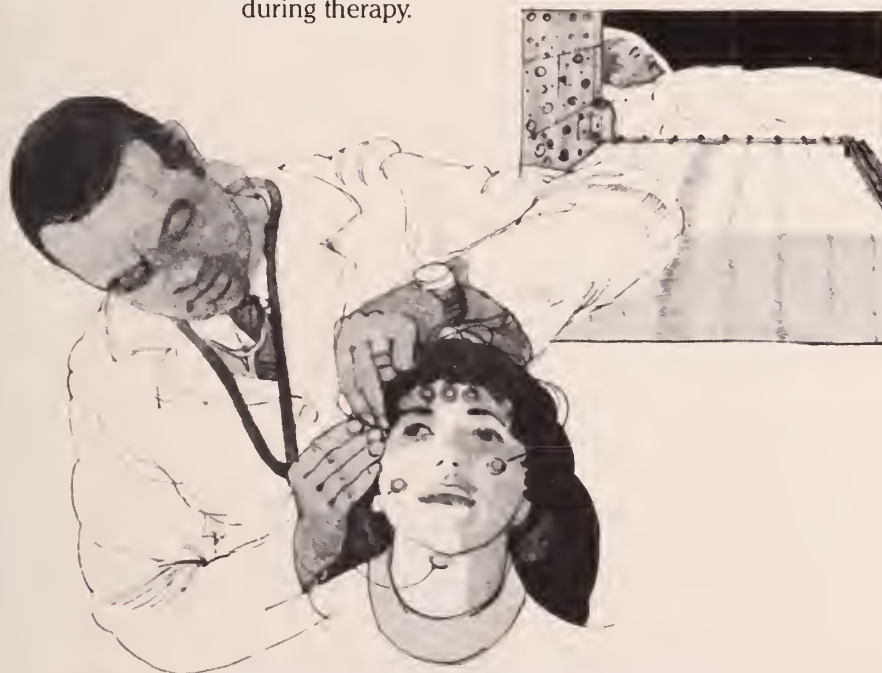
Evidence suggests that newer agents used to control inflammation in arthritis patients may also correct underlying immune deficiencies associated with the disease. In a report in the Nov. 11 issue of JAMA, researchers said that the administration of piroxicam was associated with a reduction in the production of rheumatoid factor to approximately 62% of a baseline level after ten weeks of therapy. They also reported an increase in cellular immune response, which is usually depressed in these patients.

The weight of objective evidence supports the clinical efficacy of Dalmane®

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- Studied extensively in the sleep laboratory—the most valid environment for measuring hypnotic efficacy.¹⁻¹²
- Studied in over 200 clinical trials involving over 10,000 patients.¹³
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- Contraindicated in patients who are pregnant or hypersensitive to flurazepam.
- Caution patients about drinking alcohol, driving or operating hazardous machinery during therapy.



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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

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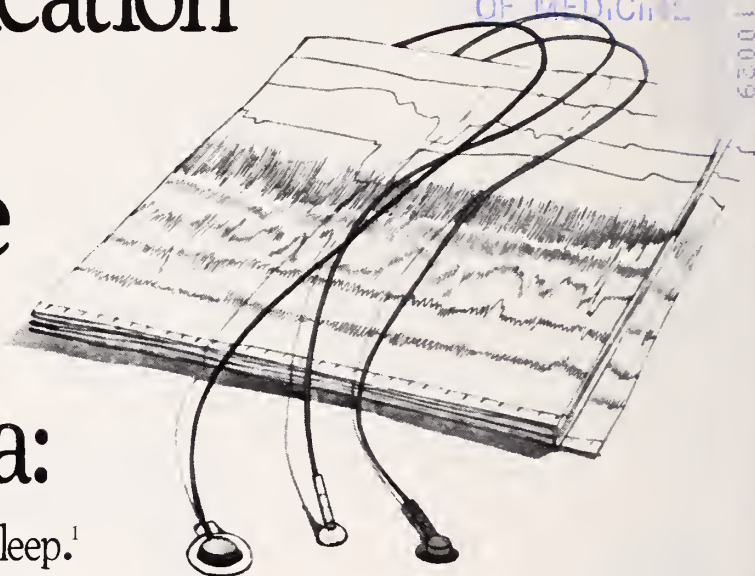
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[illegible]

